



Mental Health Literacy in the Arabic-speaking Community of Victoria

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

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Master of Social Health and Counselling (Family and Children strand)

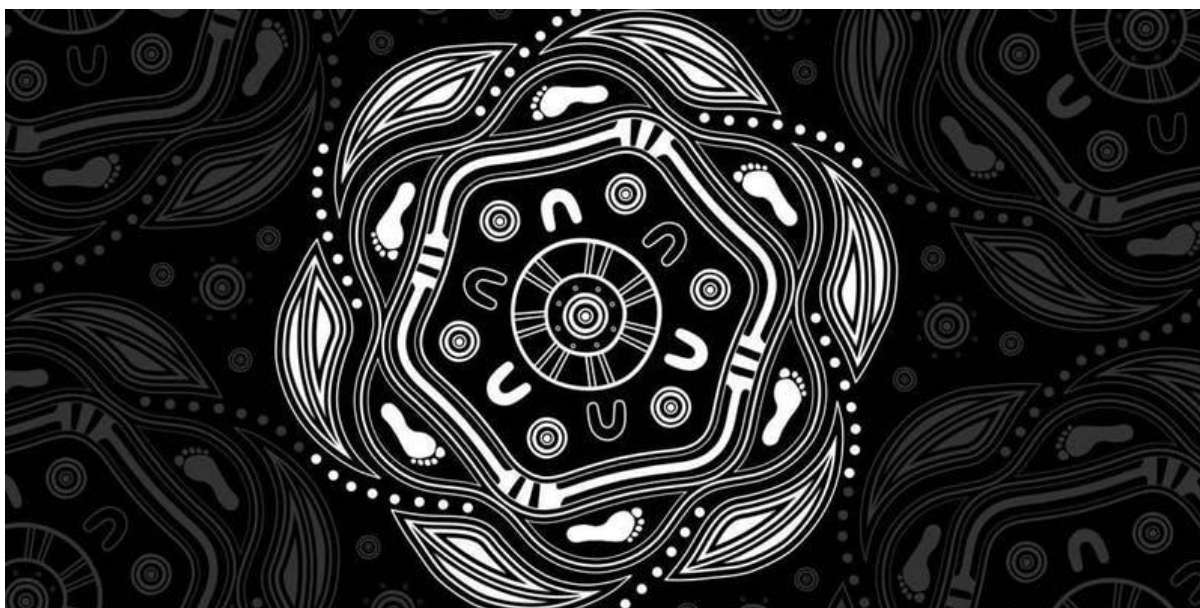
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I would like to acknowledge the people of the Woi wurrung and Boon wurrung language groups of the eastern Kulin Nations on whose unceded lands we conduct the business of the University. I respectfully acknowledge their Ancestors and Elders, past and present.

I would also like to acknowledge the Traditional Custodians and their Ancestors of the lands and waters across Australia where we conduct our business and where this research was carried out.

¹ The artwork in RMIT Reconciliation Plan was commissioned by RMIT University from Dixon Patten (Bayila Creative) - Yorta Yorta, Gunnai and Gunditjmarra.

The gum leaves around the artwork represent the unity of cultures and working together to achieve reconciliation, with both Aboriginal and Western knowledge being mutually exchanged.

The pathway with feet represents RMIT's reconciliation journey.

The larger inner circle depicts elders, community members, and RMIT working together to achieve reconciliation outcomes.

The smaller circles represent the various communities that RMIT has helped or influenced to achieve their education goals.

The dots and circles that extend out from the leaves represent life and the many pathways and opportunities that education and knowledge can provide. The ripples and layers represent the effect that education has on the broader community.

Declaration

I certify that except where due acknowledgement has been made, the work is that of the author alone; the work has not been submitted previously, in whole or in part, to qualify for any other academic award; the content of the thesis is the result of work which has been carried out since the official commencement date of the approved research program; and, any editorial work, paid or unpaid, carried out by a third party is acknowledged.

Yamam Abuzinadah

3rd Aug 2019

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Abstract

This research explores mental health literacy in the Arabic-speaking community in Victoria, Australia, and their concepts, beliefs, perspectives and attitudes toward mental health in general. This research also examines the impact of mental health literacy on help seeking attitudes, relationships and intra and inter- community understanding.

This qualitative research employed both an online survey and face to face interviews for a total of 185 men and women aged 18+ from Arabic speaking backgrounds living in Victoria, Australia. Due to the cultural sensitivity of this topic, this research used online surveys to open up the topic with the broader community, then invited those who indicated deeper interest in the topic to participate in the face to face interview. There were 165 to the online survey – and from this, 20 people participated in the face to face interviews responses. The findings shows that the concepts, beliefs, perspectives and attitudes toward mental health in the Arabic community is highly influenced by cultural and religious beliefs and practices such as: جن(jinn) , سحر و سيطSeher & Rabtt (Black magic spills and sorcery) , حسد Hassad & الحسد Al-ayn (Envy and Evil eye), عيب Ayeab (Stigma) and رجولة Rejal (Manhood). The findings also highlighting several literacy issues and complex language gaps.

The outcomes of this research will contribute to raising mental health awareness among the Arabic-speaking community, develop and enhance mental health service provision and explore new ideas regarding elevating mental health literacy in the Arabic- speaking community in a more culturally competent and sensitive way.

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Introduction

Chapter 1: Mental health literacy and the Arabic-speaking community in Victoria

1.1 Background

Mental health literacy has become a very relevant topic in Australia due to the increasing number of mental health issues that have been reported through national research and surveys. This research explores mental health literacy in the Arabic-speaking community in Victoria and the ways that Arabic culture informs perceptions of mental health in general. It also explores the impact of mental health literacy on help-seeking attitudes, relationships and community interactions. The outcomes of this research will contribute to raising mental health awareness among the Arabic community, developing and enhancing mental health service provision and exploring new ideas to elevate mental health literacy in the Arabic community.

This research focuses on the Arabic-speaking community living in Victoria, Australia, and their concepts, beliefs, perspectives and attitudes toward mental health in general. A person will be considered Arabic if they are descended from one of the 22 Arabic countries: Algeria, Jordan, Oman, Syria, Bahrain, Kuwait, Palestine, Tunisia, Comoros, Lebanon, Qatar, United Arab Emirates, Djibouti, Libya, Saudi Arabia, Yemen, Egypt, Mauritania, Somalia, Iraq, Morocco and Sudan, and speak Arabic as their main language, or it is spoken by a significant portion of the population of their country of origin. The main group of participants were Arabic-speaking community members living in Victoria.

According to the Australian Bureau of Statistics, the Arabic-speaking population represents 1.2% (280,000-350,000 people) of the total Australian population (Coffey, Kaplan, Sampson, & Tucci, 2010). The Arabic-speaking communities in Australia are diverse and include people from 13 countries: Jordan, Oman, Syria, Bahrain, Kuwait, Palestine, Lebanon, Qatar, Egypt, United Arab Emirates, Saudi Arabia, Yemen and Iraq. The proportion of people who speak a

language other than English (LOTE) in Victoria is 23.1%. It is reported that 5.5% of those are Arabic speakers (ABS, 2016).

The effects of the brutal environment surrounding a portion of Arabic people before migration, such as living with war and poverty, will contribute to making them more prone to experiencing mental health issues (Coffey et al., 2010). Despite the importance of the social health and wellbeing of any community, the attention and care given to welfare services and mental health issues in Arabic countries are sporadic (El Rifai, 1965) compared to other developed countries around the world. Thus, there are no reliable, recent research data or anecdotal evidence to reveal the perceptions, attitudes, concepts and beliefs held concerning mental health issues in many Arabic countries. Al-Krenawi (2005) suggests that mental health services for the Arabic-speaking community in many Arabic countries such as Palestine and Egypt are not as developed as they could be, and the interest in social services and welfare in its modern Western concepts, is still below the required level. This will have a major impact on migrants to Australia from such countries (Furnham & Hamid, 2014) as people who migrate or flee these countries will carry their past experiences with them, which will be a major factor when dealing with mental health issues or accessing welfare services available in Australia. A thorough review of Arabic literature has been undertaken to assess the relationship between participants' past experiences and their current views on mental health in general.

Many refugees, asylum seekers and migrants from Arabic countries are exposed to social and psychological difficulties and instability due to wars (Salloukh, 2013), poverty, human rights violations and unemployment (Al-Krenawi, 2005) before they decide to leave these countries. Hence, these difficulties would be among the major contributing factors for many Arabs to seek humanitarian aid or migrate to developed countries such as Australia, the United States of America and the United Kingdom (Benson & O' Reilly, 2009). Moreover, international students from Arabic countries might live in Australia to study and then return to their countries

or decide to stay after finishing their studies and use their qualification to settle in Australia (Al-krenawi, Graham, Al-bedah, Kadri, & Sehwal, 2009). Nonetheless, the difficult experiences and previous and current stressors people from Arabic backgrounds may have encountered in their lives before or since their migration may lead to emotional problems such as post-traumatic stress disorders (PTSD) (Jamil et al., 2002). This may be a contributing factor to trans-generational trauma and many other social, psychological and mental health problems (VFST, 2004). These and other factors will be considered in this thesis, along with the role they play in mental health literacy.

This research on the mental health literacy of Arabs living in Victoria, Australia, will potentially provide new insights and contribute to the existing but limited studies available to inform policy and service provision to Victorian Arab-speaking communities, including a better understanding of barriers to access. Perceptions about and attitudes towards mental illness and mental health treatment may affect help-seeking behaviour (A. Jorm, 2012). There is a social stigma (negative label) or shame attached to mental illness and mental health treatment in an Arab community (Bener & Ghuloum, 2011; Youssef & Deane, 2006). The research findings will contribute to further understanding the obstacles and difficulties many of the Arab-speaking communities face in accessing and using the available social and welfare services in Australia due to mental health literacy, primarily through examining and analysing the cultural, religious and social barriers they encounter. The Arabic-identifying population is increasing in Australia and elsewhere due to migration and the current war in the Middle East (ABS Census, 2016). Potentially, the findings and outcomes of this research will be informative for Arabic-speaking countries as well.

1.2 The focus and setting of the research

This research will contribute to knowledge about mental health literacy with a focus on the Arabic community, an area that is not well researched. Existing material is very scarce and inadequate. Moreover, substantial studies that specifically focus on the Arabic-speaking community residing in Victoria do not exist. Given the limited evidence of the efficacy of psychological treatments with Arab people (Gearing et al., 2012; Takriti et al., 2005), recruitment of Arabs to mental health research is an urgent priority (Kayrouz et al., 2014).

While mental health problems are a significant issue, evidence has shown that treatment helps with symptom management as well as with associated problems. The underutilisation of mental health services is a very real problem, as many who might benefit from care do not receive such benefit. However, this pattern of underutilisation is not seen proportionally among different ethnicities, cultures, or religions (Koenig, 1998; Lin, Tardiff, Donetz, & Goresky, 1978). In the United States, this trend has been documented in several studies with minorities such as African Americans (Alvidrez, 1999), Latin Americans (Alvidrez, 1999), Asian Americans (Kim & Omizo, 2003), and Native Americans (Beals et al., 2005). Very little research studied the Arab and/or Muslim minority in Australia as well.

This research, therefore, will highlight the current available studies and any gaps in the literature and inform the field by providing insights into raising awareness around mental health issues in the Arabic community. Significantly, this research will consider a community engagement approach as a means of obtaining the insight from the participants; starting with the community experts' consultation, then through an anonymous online survey. Private, in-depth interviews will also be carried out to give participants an opportunity for their voices to be heard - a neglected perspective within multicultural mental health research due to the sensitive nature of this issue. The research will draw on a community-engaged methodology (Ahmed & Palermo, 2010; Mulligan and Nadarajah, 2008, 2012) which was further supported

by short online surveys, and followed by qualitative and in-depth interviews. The methodology followed, and the data collection process are discussed in detail in Chapter 3.

1.3 Research ethics and practical considerations

A number of academics were invited to participate in a professional advisory group, and there are no anticipated adverse consequences from their participation, they were recruited to advise and share their expertise on the research part of the community-engaged approach this research adapted. After that, the remaining of the participants were invited to answer the online surveys and face to face interviews. Online survey participants were able to stop the survey at any time. There were no anticipated adverse consequences from participating in this survey before or after the data collection. The participants were also able to stop the interview at any time. The focus of the study is on mental health literacy; that is, attitudes, knowledge and beliefs of Arabic-speaking communities of Victoria. It is not targeted at people with mental illness

This research did not require the use of any specific external extra service, and translation services were not necessary to translate Arabic publications, conversation and any other used material or resources into English, due to my personal proficiency in Arabic as a native speaker. With all the above considered, I was aware that the Arabic-speaking community is a minority in Victoria, and may encounter discomfort participating in this research due to the cultural aspects of shame and stigma. However, I made sure that the participants were aware of the ethical consideration and the sensitivity of the matter by providing a detailed written explanation in English, and Arabic if needed. I also offered to meet the participants in a convenient, safe location according to their needs. The research obtained Ethics approval in 2015 (00000198830). This approval was amended on November 2017 to incorporate the community engagement methodology with a greater focus on intercultural issues (CHEAN A&B19830-11/15). Copies of the approval letters are provided in Appendix 1.

1.4 Validity and reliability

As a researcher, my perspective, background or ideology of thinking might be present in the results and could influence the outcomes. However, I was careful to observe and account of any bias that this research might encounter. Through the community-engaged research approach, I have had a framework—a “boundary”—determining how much I can be involved as a researcher and member of the community. I have employed reflexivity through autoethnography, at every step of the research process and constantly thinking about the potential of biases and how they can be minimised. I diligently and conscientiously mentioned and monitored any biases by giving the reader a clear explanation of how they may arise due to the researcher’s perspective and background. More information about this covered in Chapter 5.

1.5 Aims of the research

This research explores attitudes, beliefs, perspectives, values and perceptions regarding mental health among a targeted and location-based Arabic-speaking community, as identified in the earlier part of this chapter. It also highlights the factors contributing to these beliefs, perspectives, values and perceptions, and the role these factors play in raising awareness, increasing services access, recovery and care provided by the family and the community. In order to generate a substantive understanding of these cultural values and perspectives, research questions must be designed to provide the freedom and flexibility to explore the phenomenon in depth. Hence, for this research study, the central research questions are as follows:

- What is the impact of cultural factors on mental health literacy; that is, attitudes, beliefs, knowledge and skills?
- In what ways does culture inform and influence perceptions of mental health literacy?
- What is the impact of mental health literacy on help-seeking behaviours?

1.6 Research questions

The main research question for this thesis is as follows:

What is the mental health literacy of the Arabic-speaking community in Victoria?

Accordingly, this researcher investigates the following questions in the surveys and interviews:

- What are the perceptions of mental health in the Arabic-speaking community?
- What are some of the religious beliefs surrounding mental health issues in the community?
- What are some of the cultural traditional healing methods used for people who experience mental health issues?
- How is emotional distress or mental health issues identified?
- What is the language, expressions and vocabulary used to express mental health and wellbeing in Arabic? How does that impact mental health literacy?
- How does all the above affect the approach to accessing Western mental health system?

1.7 Locating the research and myself as a researcher

I found the need to locate my story, to locate myself as a female, as a Muslim and as a mother within my own community. I would draw on the work of great poets like *Waheed* (2013) to find solace and also a determination to unravel so many of these complex conundrums, whilst also holding the richness and depth of my culture and people.

*The beauty of my people
Is
So
Thick and intricate
I spend days*

*Trying
To Undo my eyes
So
I can sleep
-lace*

(Waheed, N., 2013, p. 93)

I was born and raised in Saudi Arabia; I left in 2007 with a plan to learn more about human behaviour and feelings. Growing up in this Saudi culture, in an Arabic community with so many beautiful memories, I've heard so many of our so-termed "abnormal" relatives and community members being unfairly and wrongly described as crazy, possessed or evil! Many of them were experiencing mental health issues and often remained untreated or even worse, shunned by family members themselves or society for years. I am yet to try to understand all of the above. Often this is a gut-wrenching situation – and often I have tossed between the pride of where I come from, but also trying to hold the dissonant issues of aspects of this same culture, especially with regard to the way people with mental health issues were regarded and treated. Being so much a part of my own culture and people was both poignant yet challenging.

I became very interested in mental health at an early age and sought to understand and gain more knowledge about the explanations my community gave about mental health issues, and the experiences I had with my family. In 1991, Eid Alfetir, the biggest Islamic holiday that follows Ramadan, we drove around in my father's car for the traditional Eid visitation run, which is usually visiting close family member- and God we had a lot- and of course every living elder in the family! So, we got in my uncle's house, greeted them, coffee, chocolates and dates, then hit the car, next home and so on for at least 6 hours non-stop for 3 days!

Then on the last day, 7 pm, we were driving to visit my father's late uncle's wife "Om Abdullah" and her family, a wealthy Saudi Hijazi family. It was not the first time to visit them, but this time was remarkable, and the first after he passed away. As we walked into the huge

fancy mansion's grand entry, floors covered in white marble I saw Aunty Om Abdullah resting on a day bed, posh white sheets, washing her hand vigorously 10 times in a row. The one-hour visit we spent there, I can still recall that day's heavy air, I still remember that orange "tasht" traditionally used for laundry in Saudi, filled with water and soap, the smell of a very well-known moisturiser, Blue Neiva, filling the air after every single wash while her "servant" sat on the chair to help with her ritual. I remember that on the way out, I asked my mom what she was doing. She replied, "Do you see how fancy is her house, and how "Masha Allah" she is wealthy? This is what happens when you do not do "tahsseen" and do not read the Quranic verses to protect yourself. You are sure to be affected by "Hassad" evil eye, and you'll be "mo tabeae" abnormal." My six-year-old mind was wondering *why do some people behave in a different way?* and *why is it wrong*, and *what is the "right" way to behave?*. I needed to know why.

My mother's answer did not convince me, labelling her and calling her abnormal, I did feel sad for her, I wanted to help her to get out of her "abnormality", and I was so naive! I went to pursue education, which opened my eyes to many things within my own culture and community. I was then trained as a counsellor and hypnotherapist, and then graduated with a master's degree from Macquarie University in Sydney just, then to figure out that my community lacks awareness about mental health issues. I was then "officially" appointed as the unofficial counsellor of the Saudi Community in Sydney! As I was working for 6 years as the head of the ladies committee in the Saudi student association in Sydney- as a volunteer- and I have run so many community educational sessions and workshop in Arabic for them about mental health. I remember always thinking: *how would people be able to manage a problem if they know nothing about its existence?*

The fear of stigma and shame plays a major role, as do how some religious and cultural beliefs affect perceptions of mental health issues. I knew then that I had a deep passion about spreading

awareness around mental health issues as I believe that with education and knowledge we empower the community and help them to make their own plans when it comes to recovery, healing and services access. I was then accredited in the Mental Health First Aid course, and upskilled my knowledge through other educational courses on depression with the “Black Dog Institute”. I witnessed massive improvement in many people’s awareness about mental health issues after attending the educational sessions I ran, as I used a culturally appropriated “language” to talk about mental health—and in Arabic. I realised how this affected many people I care about, including some of my family members. So, I started working with Uniting Care mental health in Sydney while I was collaborating with Cumberland Hospital “Transcultural mental health”, the Arab Council of Australia, the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), HEADSPACE, and Lifeline (Non-profit crisis support) as a mental health bilingual trainer and educator. At the same time, I was working as a volunteer for the Saudi International Student Association. In 2015, I was accepted into RMIT and decided to leave a much-loved job in Sydney, leave my community and be separated from my partner, to immerse myself in research and to seek knowledge and understanding of the current research around mental health literacy in the Arabic community. My goal was to make a contribution to knowledge about and raise awareness of mental health issues in the Arabic community.

However, after moving to Melbourne to start my PhD, I was invited to serve as an advisory committee member on the Ethnic Communities Council of Victoria (ECCV), and have established a Mental Health Project with them that aims to give recommendations to the State Government and the Department of Health about mental health and ethnic communities. I am also part of the working group in the Victorian Transcultural Mental Health Department (VTMH) in St. Vincent’s hospital as a consultant on improving mental health in the multicultural community.

I have been, since, training and educating people from Arabic-speaking background for some years now, about mental health, and every single course or session I run I feel amazed by the power of knowledge and education, on many occasions I had participants coming out to chat after courses about “suspecting” mental illness either faced by a loved one or them personally, and that moment of acknowledgment and realisation has made me a believer in the power of awareness and education. After all, you cannot solve a problem if you don’t know you have one, and with mental illness, the symptoms and impact will have a great deal on their daily life, thus, in many cases, their willingness to live or attempted suicide as a matter of fact, and currently suicide rates are going up (ABS, 2016), the direct impact of many mental health issues –like anxiety- on work performance and increased sick days, and many other factors that really impact people daily life will increase. Being part of the Arabic-speaking community, studying it, and being considered in my smaller circle as “an expert” due to my degree in counselling and professional experience in the community terrifies me sometimes! Saying this and reminding myself of this great ~~this~~ responsibility, I can see how mental health awareness could be improved, with proper academic exploration, that is backed up with literature review and advice from the key community members. Nevertheless, I am aware that reflexivity is an important but questioned and sensitive concept. I know that I should keep in mind the bias that I might encounter, and how my identity and experience might have an influence on the design, implementation and interpretation of the data collected and conclusions, which will demand a constant level of awareness and reflection on the multiple ways that will influence the research process and outcomes.

I used autoethnography as one of the methods to enable me to work through this question of locating myself in this research, whilst also balancing the background, experience and professional practice that I bring to this research. Autoethnography as a research method is discussed in detail in Chapter 3.

1.8 Approaches to understanding the study

This research adopted an approach that is underpinned by a community-engaged research methodology, through examining culturally sensitive research fields like mental health and culturally and linguistically diverse (CALD) communities. Drawing on a theoretical framework of grounded theory have aided to consolidate the research process. Gaining an understanding of the matter did require giving the community the space to make their own definitions and meaning of mental health literacy, rather than imposing ontological measures or ideology that have been developed through a Western lens of understanding. By using the community-engagement framework, I will be taking an Autoethnographic approach (Holman, Adams & Ellis, 2013) in this research, which will be acknowledged and embraced. Interaction with the community will be useful to address my “insiders” status (Zempi, I. 2016), giving the participants a feeling of connectedness and the space to be understood in a culturally appropriate and sensitive way. Community-engaged research (Ahmed & Palermo, 2010) will help to explore the mental health literacy of the Arabic community. This will be achieved through a theoretical exploration of grounded theory, and by gaining insights that are grounded or rooted through observation of this issue. It will also maintain the truth is created by the meanings and experiences of any given community.

Grounded theory helps in generating analytical tools and methodological strategies that can be used in this research without endorsing a prescribed theory of knowledge or view of reality (Charmaz, 2006). Grounded theory is defined as “the discovery of theory from data systematically obtained from social research” (Glaser and Strauss 1967, p. 2). Glaser and Strauss were the pioneers of grounded theory, recognising it as an important qualitative research approach during the 1960s in the United States of America. They have established a unique methodology to address some of the issues that face social research as a flexible, ever-changing field. Several approaches and versions of grounded theory exist, and the chosen one

depends on the needs of the researcher and the type of social research that is planned. However, there are three mainstream versions of it, as discussed below. Moreover, it is useful and important to identify where one stands as a researcher from the perspective of grounded theory, rather than simply using it to drive one's thesis.

The main concept of grounded theory is to create and develop a core idea around a phenomenon or issue of interest. However, it is not merely a suggested perception but rather needs to be grounded or rooted through observation of this issue or phenomena (Glaser & Strauss, 1967). The approach was first introduced by Glaser and Strauss in the 1960s. However, due to the flexible nature of this approach, it was developed and changed through the following years. They began constructing this theory while undertaking the research that led to their book *Awareness of Dying* (1965), which was the first study focusing on dying hospital patients, and has become a useful handbook for chaplains, social workers, nurses and doctors when confronting the many ethical and personal problems that arise in such situations. The anticipation of death by both the dying and their relatives was the key to understanding the interactions between those people. During that study, they had noted and criticised typically unpacks the phenomena through theories, in an attempt to explain some studies that do not comply with 'typicality' like death (Moore, 2009). Glaser and Strauss (1967) had also noted that one of the important concepts of grounded theory was not to verify or prove a preconceived theory, but rather to explore the underlying ambiguity from the systematic analysis of the process. "Verification has primacy on the current sociological scene; the desire to generate theory often becomes secondary, if not totally lost, in specific researches" (Glaser & Strauss, 1967, p. 2). The study is cited in the references for further information (Glaser & Strauss, 1965). Glaser and Strauss (1967, p. 6) argued that it was necessary to generate theory from the results of the social research itself, allowing it room to correspond with any given issues, which they believed would be "more successful than theories logically deduced from priori assumptions".

In the 1960s, there were other approaches to social research that were dominant, particularly in American sociology, such as Grand Theories that were applied in most social researches (Kenny & Fourie, 2014). Through that era, the need was clear for a more flexible approach in social research, which would allow the researcher to use their theoretical imagination instead of meticulous methodologies. Establishing grounded theory offered a revolutionary research approach, such as linking the data analysis with theory during data collection, which was only common with ethnography at that time (Morse, 2009).

During the 1960s, Glaser & Strauss were trying to generate a new theory, which was not the typical approach to social research at that time. Most sociologists would “seek out small gains of knowledge from existing ‘grand theories’ rather than explore new areas not covered by existing theories” (Glaser & Strauss, 1967). They also noted that most previous theories were generated through logical deduction rather than being drawn from the data itself. Moreover, in their approach, they established new ways to simultaneously carry out data collection, note-taking, coding and memoing right from the beginning of the research. Later, other versions of grounded theory developed, as Glaser and Strauss went their separate ways due to their career interests, differences in interpreting their own creation, and due to the fast development of social research. In 1990, Strauss and Corbin published their book *Basics of qualitative research: techniques and procedures for developing grounded theory*. In this book, they created a ‘recipe’ to grounded theory methodology, which did not match Glaser’s ideology. Glaser then criticised it as not being the original, classical approach to grounded theory, arguing that Strauss and Corbin’s approach did not extend understanding of grounded theory, but had gone on to develop another method entirely.

At that point, two main streams of grounded theory emerged; the first referred to as “Straussian”, which focuses more on qualitative data analysis, and the second known as “Glaserian”, which highlights a theoretical sensitivity approach (Morse, 2009). Glaser

developed a different way of looking at the theory and published the book *Theoretical Sensitivity*, which was another remarkable milestone, in 1978. Theoretical sensitivity is defined as:

“... a personal quality of the researcher. It indicates an awareness of the subtleties of the meaning of data. One can come to the research situation with varying degrees of sensitivity depending upon previous reading and experience with or relevant to an area. It can also be developed further during the research process”. (Strauss & Corbin, 1998. P. 41-42)

Grounded theory now has three main models that are commonly referred to in social research; Classic Grounded Theory (CGT) (Glaser 1978), Strauss and Corbin (1990) Qualitative Data Analysis (QDA), which is sometimes referred to as Straussian Grounded Theory and focuses mainly on theoretical sensitivity, and finally, Constructivist Grounded Theory (Charmaz, 2006). However, Fernandez (2012) has highlighted a fourth model, which is Feminist Grounded Theory by Wuest (1995), which will be explained later. While less known variants of grounded theory exist, these are the main grounded theory methodologies widely used in academic research.

Glaser’s approach, known as classical grounded theory, incorporates the use of many forms of methods (qualitative and quantitative), as any of these are considered as data (Glaser, 1992). He also argues against the need to transcribe all the interviews gathered through the research, suggesting that the less formal approach of taking notes is enough. In addition, he considers the use of many coding groups to be useful. On the other hand, Strauss and Corbin have a more flexible approach than Glaser that focuses more on theoretical sensitivity, as defined above. Moreover, their approach suggests that only axial coding, selective coding and open coding be used throughout their research approach (Strauss & Corbin, 1998).

Some critics highlight that the older approaches to grounded theory do not work so well with certain groups, such as minorities, and with other gender identified issues; for example, Wuest (1995), who argued that Feminist Grounded Theory is an example of devolving a theory in the modern research view. It has given space and credibility to women's rights and feminist theory in the research community. Initially, it was developed for nurses in recognition of the androcentric bias that was criticised by social researchers. However, the move in social science towards postmodernism and poststructuralism has resulted in GT being attacked for its objectivist and positivist foundations. Wuest's (1995) book, *Feminist Grounded Theory: An Exploration of the Congruency and Tensions between Two Traditions in Knowledge Discovery*, gathers methodological elements from the CGT, QDA and Constructivist grounded theory models to highlight the importance of merging grounded with feminist theory, as "grounded theory is consistent with the postmodern feminist epistemology in its recognition of multiple explanations of reality" (Wuest, 1995, p. 127). Feminist grounded theory is highlighted as an example of how the older versions of GT might have a bias toward culturally sensitive groups in research. However, the constructivist GT approach (Charmaz, 2006) will be more appropriate to use in this research; this will be further explored below.

After the historical theories emerged and evolved, and following the abovementioned main approaches, theorists and social researchers started exploring and studying grounded theory. The key people who contributed to grounded theory are Charmaz (2010, 2006); Clark (2003, 2005, 2006); Schatzman (1991); Bowers (1987); and Caron (2000). An outline of their work follows. Many social researchers and theorists have studied and used grounded theory, and some of them have referred to it in different ways. Creswell (2013) highlights the three main grounded theory approaches—CGT, QDA and Constructivist—but refers to them as emergent (Glaser & Strauss), systematic (Strauss & Corbin), and constructivist (Charmaz). Denzin (2007) expands the argument to state seven approaches, which he calls positivist, computer-

assisted, constructivist, objectivist, postmodern, situational, and post-positivist. On the other hand, Babchuk (2009) highlights four approaches that consist of the two traditional versions of Glaser and Strauss, also called emergent and systematic, plus the theoretically repositioned approaches of Charmaz and Clarke, which are labelled constructivist and postmodern and situational. Evans (2013), on the other hand, considers a fifth-dimensional analysis by Bowers & Schatzman (2009).

While competing interpretations contribute to the historical view of GTM as a “contested method” (Charmaz, 2006, p. 134; Bryant & Charmaz, 2007a, p. 3), some argue that the diversity inherent in these different approaches “needs to be seen as basis for the discussion and exchange of ideas and not as an excuse to erect barriers between one ‘true’ version of GTM and all others” (Bryant & Charmaz, 2007b, p. 48). However, the 1960s grounded theory has evolved naturally, to become the foundation of much social research and a new way of investigating the social world (Evans, 2013)

While working with Strauss on *Strategies for Natural Sociology* in the 1970s, Schatzman (1991), one of the key contributors to the development of grounded theory, started to use analysis in dimensional matters and wrote his book *Dimensional analysis: Notes on an alternative approach to the grounding of theory in qualitative research*, due to the limitations he saw in grounded theory. His work was noted by Strauss as an “approach” or new theory (Morse, 2009). Dimensional analysis, like grounded theory, highlights theory generation coming directly from data, as Schatzman appreciated the power of constant comparison. However, it does not fulfil the need for a deeper understanding as the analysis/perspective needs to be viewed in a much more expansive and complex way.

Another important version of grounded theory that will be used in this research was developed by Charmaz (2006) and is a constructivist version of grounded theory, which considers the constructivist critique on mainstream research during the 1980s and 1990s. Charmaz’ main

argument is that the researcher is a co-constructor of the meaning. She believes that the concepts and meanings drawn from the data or the research are not simply derived from the participants, but rather are co-constructed in the interactions between the researcher and the research participants (Charmaz, 2014). Moreover, she suggests using a combination of procedures by Glaser and Strauss, which offer more flexibility to social researchers, such as using open coding and axial coding as needed. However, at the same time, Charmaz approach is open for constant comparison and theoretical sensitivity. Moreover, grounded theory, as suggested by Charmaz (2006), is a complex and ramified processes to some extent. The research begins with formulating questions in an analytical exploration approach, which has no static or confining goals. When the researcher starts to gather data, core concepts may start growing and forming links between the theoretical core concepts and the data. This stage may take a long time. In the following stage, the researcher starts to summarise the data found and establish verification, which will shape a central main concept to the research (Charmaz, 2006). On the one hand, Charmaz (1995, 2002) identifies that all grounded theories have a feature in common, which is data collection occurring simultaneously with analysis. Unlike theoretical sensitivity, Charmaz' approach uses the data to develop analytic codes, rather than use pre-existing conceptualisations. It also draws on the basic social processes in the data, as it uses theoretical sampling to refine categories in order to integrate them into a theoretical framework. Between coding and writing, analytical memos can be used. On the other hand, Charmaz identifies the coding style in her grounded theory as a process for both categorising qualitative data and for describing the implications and details of these categories (Trochim & Arora, 2015). According to Charmaz (2006), open coding will help to create detailed information, which will be developed into specific categories. From there, the researcher can work towards more selective coding, which will lead to the core concepts of the study.

Another feature is “memoing”, which involves the researcher recording their ideas and thoughts throughout the study. When the researcher starts the processes, it tends to be general or open, but as the process progresses further, memoing can help in shaping the main research “core” concept. Charmaz also suggests using integrative diagrams and visual tools as another analytic strategy, as this helps the researcher to layout their ideas clearly, and gather up the concepts into a visual graphic. These diagrams contain graphics that easily describe the development of the concepts and theory such as maps, directed graphs or simple photos that could illustrate the idea. These key analytical strategies will help the researcher to create a “conceptually dense theory as new observation” (Trochim & Arora, 2015), which will be a pathway linking the theories, concept and data collected.

However, to summarise the development of Grounded Theory, it is noteworthy that in 1967, Glaser & Strauss released the book *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Then, by the 1980s, further research by Glaser and Strauss took them in different directions, and the *Basics of Qualitative Research* was released by Strauss and Corbin in 1990. Nevertheless, Glaser (1992) suggests this does not extend understanding of grounded theory but has gone on to develop another method entirely. In 1998 *Basics of Qualitative Research 2nd edition* is released by Strauss and Corbin. Whilst not responding directly to Glaser’s criticisms, it is less prescriptive. It is not clear whether these two schools of thought are actually different or whether they are just expressing a similar idea in different ways (Melia 1996). Charmaz (2006) adopts a constructivist grounded theory approach, where the researcher can move grounded theory methods further into the realm of interpretive social science consistent with a Blumerian (1969) emphasis on meaning, without assuming the existence of a unidimensional external reality (Charmaz 2000, p.521). This theoretical perspective answers some of the criticisms of modernist grounded theory. As in other constructivist methodologies,

a constructivist GT arises from the interaction between the researcher and participants, the researcher's perspective being part of the process.

How does grounded theory serve in conceptualising this research? This research approach in studying experiences is grounded in the community's perspectives, concepts, beliefs and understanding around mental health, and is also in line with the constructivist grounded theory (Charmaz, 2006) that guides the methodological framework of this thesis. Grounded theory, as a qualitative method, offered the flexibility needed in this research. It has also helped to shed light on the positive and negative beliefs, perspectives and views that the community holds about mental health issues. Grounded theory serves well when working with culturally sensitive groups, as the research and the methods used have to accommodate the community's need to feel understood and safe. Another important reason for choosing constructivist grounded theory is that it works well when using community-engaged research, and it helps with simultaneously collecting data from the participants and analysing it. This will be explained in-depth in the methodology Chapter 3.

Using this approach helped the community to explore its own ideas within a culturally appropriate platform, suggest positive steps toward fighting stigma and explore its understanding of mental health literacy in accordance with the recognition of its existence. This research used a more constructivist approach to grounded theory, following Charmaz' approach, as there is more focus on context and complexity, and it is not as procedural as Strauss' and Cobin's approach. The complex nature of mental health issues in this context and complexity needed cooperation and co-construction of the inquiry at hand regarding mental health literacy to address "how people draw on socially constructed discourses" (Charmaz, 2006, p. 142) and to answer the question of how the Arabic-speaking community understands mental health literacy. Furthermore, it has helped me as an insider-outsider researcher, part of the Arabic-speaking community and a mental health professional, to form a better

understanding of mental health literacy with the community together. Constructivist grounded theory allowed me the possibility of investigating multiple meanings and multiple theories around mental health.

Grounded theory has complemented the research method – substantive interaction with the community - by enabling the thesis to develop a framework and illustrate new ideas, which offered an explanation and understanding about mental health literacy and its extent/existence in the Arabic-speaking community in Victoria, through substantive interaction with the community. This has been explored in Chapter 7, to establish future recommendations, as Charmaz (2009) suggests, to understand how “participants’ meanings may reflect ideologies; and their actions may reproduce current social conventions or power relationships” (p. 131). Grounded theory helped with stating outcomes and understandings to generate recommendations for future studies, which hopefully will lead to positive change in mental health awareness and education (Richards, 2007).

The use of GT produced practical outcomes for this research, and the anticipated outcome gives an exploratory insight into the views, concepts and understanding of mental health issues held by the Arabic-speaking community of Victoria, as it is noted “how people draw on socially constructed discourses” (Charmaz, 2009, p.142) gives an exploratory insight into understanding mental health literacy. Grounded theory enabled the involvement of community participation, which is a very useful tool to study culturally and linguistically diverse communities. Community involvement benefited from community-engaged research, which is compatible with grounded theory. It informed the methods of this research, as the targeted group is a culturally diverse population that will be better understood through respecting, valuing and understanding their concepts, beliefs, perspectives and attitudes toward mental health in general, and how this is shaped by many social and psychological factors.

Due to the lack of adequate theoretical understanding of mental health literacy in non-English-speaking communities, grounded theory will help establish and draw new perspectives from the data collected through community-engaged research. The main idea behind using community-engaged research in this study is to emphasise participation and action between the researcher and the community, gauge the community's level of mental health literacy and improve it in collaboration with community reflection and the researcher's observations.

1.9 Limitations of the study

This research seeks to gain much deeper insight into the Arabic community's understanding of mental health literacy and the cultural, intercultural and intercultural issues and challenges associated with these. The number of people who consider themselves from an Arabic background in Victoria is limited, and they are considered a minority (1.4% of the Australian population) according to the reports from the ABS (2016); therefore, this research may face possible limitation in the number of participants.

While this research is an exploratory study, the findings may shed light on mental health stigma in the Arabic-speaking community, and encourage further research into enhancing literacy and raising awareness of mental health in the Arabic-speaking community.

1.10 Outline of the thesis

Chapter 1: the current chapter is mainly an introduction to the research and includes the validity of the research, the research questions, locating the research and the outline for the thesis

Chapter 2 is focused on locating the Arabic-speaking community: This chapter will deal with locating the Arabic community aiming at identifying them historically, socially, culturally and politically. Identifying these factors will provide an overview of the targeted group for my thesis, which will help the reader to have a better understanding of the Arabic-speaking community and the Arab world. This chapter will be aiming to highlight the differences,

diversity and areas of commonality in the Arabic-speaking community considering culture, politics and history, in order to unpack and understand the researched community from an outsider's perspective.

Chapter 2: Locating the Arabic-speaking community: culture, history and politics

2.1 Introduction

This chapter is about locating the Arabic community aiming to identify them historically, socially, culturally and politically in to understand myself as researcher and practitioner who is from an Arabic background and what it means to use the term Arab, Arabic and Arabic-speaking people – and the complexities behind such terms and the various interpretations of these, both within the Arabic community and the non- Arabic community. In order to understand Arabs, this chapter will investigate their historical origin and the development of their ethnicity, and the countries that are politically considered Arabic. This thesis has a specific focus on the language aspect and is only concerned with Arabs who are Arabic speaking, which is the main distinction between the members of this minority group in Victoria. Furthermore, for the purpose of identifying the Arabic-speaking community that is to be included in this research, a person will be considered Arabic speaking if their first or main language is Arabic. It is very important to locate the Arabic-speaking community because as I often feel that I am sitting at the intersection of complex issues when locating and defining the term Arab, Arabic speaking and or Arabic culture. This in itself is a contested and political area, and my aim here is not to unpack it from a political perspective, but to look at some fact, history and culture understanding; as ‘ethnicities’ and ‘communities’ seem to be ‘several’ identifiable Arab identities

Firstly, this chapter presents a brief history of the Arab world and how Arabs used to be politically identified as a “race”, then gives a description of the Arabic culture in terms of identity, religion and the significance of the Arabic language in the Islamic world through the holy book of Islam, the Qur’an. Furthermore, a review will be carried out of the literature on the history of Arabs in relation to Islam as the main practised religion, followed by some useful insights about the role of religion, as it plays an important part in Arab culture and identity.

Secondly, this chapter considers the Arabic-speaking community in Australia by identifying the home countries of migrating Arabs, and the history of their arrival in Australia. It will then specifically look at a range of demographic information, the culture of the Arabic-speaking community in Victoria, and provides a brief review of the main community-service outlets available for the Arabic-speaking community in Victoria.

2.2 Arabs in the world

The World Bank estimates the population of Arabs around the world to be 406,452,690 people (WB, 2017). There are millions of people around the globe who consider themselves Arab; however, the underlining criterion for what defines a true Arab makes for an interesting and complex argument. Arabs are not a group that can be identified by distinctive skin colour or ethnicity. Language may be considered a big factor in helping to determine who is Arab; however, although some Jews in Palestine speak fluent Arabic, they are not considered Arabs (Al-Krenawi, 2014). They are rather Israeli citizens residing in a colonised Arabic country (Barakat, 1993). According to Patai (1973), in pre-Islamic times, the term “Arab” referred to the people who inhabited the Arabian peninsula and the Syrian desert. Jabra (1988) views Arabs as “anyone who speaks Arabic as his own language and consequently feels as an Arab” (p1988). The question of who is considered an “Arab” is a highly contested and political question; it will be addressed in this chapter through a review of the literature in this area. But while this thesis focuses on studying the Arabic-speaking community in Victoria, it is vital that this is contextualised both within the national border and globally. This will provide much more nuanced insight into the diversities of these people as well as the commonalities, as Arabic-speaking countries differ immensely from one another in terms of their history, culture, politics and dialects,

2.3 Political and cultural background

Looking back into history, some scholars such as Ali, J. (1980). think that the descendants of Islam's Prophet Mohammed who reside in the Arabic peninsula, are Arabs. Furthermore, some believe "pure" blood descendants from many generations of the original Arab tribes—explained next in the history section—are "the" Arabs (Patai, 1973). Politically speaking, the Arab world is a region composed of countries in the Middle East and North Africa where Arabic is the official language, and which is politically represented through the Arab League and the Cooperation Council for the Arab States of the Gulf. There are 22 Arab countries, being: Algeria, Jordan, Oman, Syria, Bahrain, Kuwait, Palestine, Tunisia, Comoros, Lebanon, Qatar, United Arab Emirates, Djibouti, Libya, Saudi Arabia, Yemen, Egypt, Mauritania, Somalia, Iraq, Morocco and Sudan, as shown in Figure 1. These countries' main language is Arabic, and Islam is the main religion (Sorenson, 2008). However, this political definition of home country is general, and the description may not apply to all people, as individual experiences may vary. The Arabs are mostly located in the Arabian Peninsula "Aljazeera Alarabbyah" *الجزيرة العربية*, which is made up of Oman, Bahrain, Kuwait, United Arab Emirates, Saudi Arabia, Qatar, Yemen and Iraq. With the exception of Yemen and Iraq, these countries form a group known as the Cooperation Council for the Arab States of the Gulf, which holds the most powerful position both politically and financially in the Arab world due to its oil trade and rich economy (WB, 2017).

Along with over 400 million Arabs, Arab countries have a rich diversity of ethnic, linguistic, and religious communities, including Kurds, Armenians, Berbers and others. It is important to note that Iran, Turkey and Pakistan are not Arab countries, but they are part of the Middle East (Sorenson, 2008), and many of their citizens speak fluent Arabic as they are Muslim countries. Many Muslims learn Arabic to gain a better understanding of the Qur'an, which is written in Arabic *قرآن*, and other old religious manuscripts without the need for them to be translated

(Nydell, 2012). This will be explained further in the Arabic language section below. The relationship between the Arabic language, Arab countries, Arabic-speaking community and Islam as religion will also be explained further below.

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Figure 1. Countries where Arabic is spoken

2.4 History of Arabs in the world

Historically, before the emergence of civil rights and national identities in the Arab world, a person could be identified as an Arab if they were a descendant of Arabic tribes (AbuKhalil, 1992; Patai, 1973; Sullivan & Ismael, 1991). However, nowadays, the term Arab denotes a homogeneous, distinct ethnic group that culturally shares little commonality (Nydell, 2012). The Arab League and the Cooperation Council for the Arab States are important unifying sources for the Arab nation, on the basis of cultural homogeneity among Arabs in political and religious aspects (Ali, J., 1980).

Many Arab scholars have written about the origin of the Arabs and from where they have come. One of the pioneer historians, Jawad Ali, has published an extensive record of the historical origins of the Arabs, entitled “History of the Arabs before Islam” الفهم لفيت اريخ لالعرب in his series of 10 volumes, which were printed in Beirut between the years 1968 and 1974. These books are considered encyclopaedia as they form one of the most important Arabic history resources ever written. As Ali studied history at the German University, he was mentored by Leopold von Ranke, and his lifelong work was influenced by Ranke’s methodology, which describes history in precise language and without imposing any personal perception. Ali’s work is written in Arabic, which gives me as a researcher an accurate insight into the authentic historical information that I studied through my school years in Saudi Arabia, using his work as a reference. The complete collection of his books has been reviewed, and

some of the important quotes have been translated for this chapter. There are other scholars who have studied the Arabs such as Hitti (2002) and Hourani and Hourani (2002), who provide well-written documentation of Arab history in English. All of these studies provide similar historical facts but convey different perceptions when interpreting the culture. Ali's clear Arabic narrative about Arabs is free of personal perceptions and subjective cultural interpretations, providing a valid reason to cite his work more often than other studies.

Many references indicate that the origin of the Arabs as a race goes back to the Prophet Noah, or more precisely his son, Sam Ben Noah. Ali, J (1980) reports that the Arabs lived in Mesopotamia (now most of Iraq plus Kuwait); and some of them migrated to the Arabian Peninsula to settle there. These migrants were identified as "the Arabs." According to Ali, J (1980), these Arab tribes then divided into two groups.

The first group was known as "العرب البائدة" extinguished Arabs", as these were people who eventually returned to their original land. This group settled in four different locations on the peninsula. Those called "Gawm(folk) A'aad قوم عاد" settled in "Ahgaff", which was a desert area in the southern part of the Arabian Peninsula. The "Gawm(folk)Thamud قوم ثمود" were those who dwelt in a valley called "Wadi Alqura", an area located between the "Hijaz", which was a region in the western side of present-day Saudi Arabia, and the Eastern Mediterranean Levant (now Alsham and Madain Saleh) in the northern region of the Arabian Peninsula. Other tribes were known as "TaSeenMeem" and "Agdis", who inhabited the "Alyamamh اليمن" area in the centre and eastern part of the Peninsula. These groups were all extinct before the descendant of Islam, and are identified historically as "ancient Arabs".

The second group was the Arabs that remained "العرب الباقية" Alarab Albagya. They divided and settled in two different locations. The first tribe was called Arab Arebah "عابه", like "Qahtan قحطان", who lived in Yemen in the south of the Arabian Peninsula. They are called "The Arabs" as they used to be considered the origin of the Arabs due to their direct descendant,

Sam Ben Noah. Some of these tribes; for example, “Awss” and “Al-Khazraj” **أوس** و**ال**خزرج, were the first Arabic-language speakers who used the original pronunciation of the native language, which is still formally considered their language. The second tribe, called “Mosta’arebah **مستعربة**”, meaning descendants of the Prophet Ismail, they were the tribes of “**ع**دن **ل**يون” Adnanyyon” who lived in the north of the Arabian Peninsula such as “**ق**يس **س**” Qais” and “**ع**ن **ل**ان” Eilan. They are a descendant of “**ق**ريش” Quraish” who resides for centuries in Mecca, their language is the original Syriac from Iraq.

2.5 Culture: identity, religion and the Arabic language

It might not seem easy to identify Arabic culture, due to the diversity of religion, social norms, politics, dialects and costumes that exists. One might wonder whether there is, in fact, such a thing as Arabic culture, given the diversity and spread of the Arab region. The identity of people, in general, is something accumulated and built through life experiences and many other factors. However, what does it mean to be identified as Arab, and what is the meaning people attach to identifying themselves as Arabs? Despite the many differences among Arab identity, Arabs “are a clearly defined cultural group and perceive themselves to be members of the Arab Nation “**ا**ل**ع**ربي**ة** **ا**ل**ا**مم**ة** **ا**ل**ا**ر**ب**ية” (Nydell, 2012, p. 67). The combination of identity, religion and the Arabic Language is a good indication of the culture within the Arab nation (Patai, 1973), which changes with age, country of birth, financial status and many other psychosocial factors (AbuKhalil, 1992). The Arab nation has many aspects that are drawn from its history. According to Ali, J. (1980), Arab culture is derived from practices that have existed in older generations, and some are pre-Islamic. Islam and Islamic culture have, indeed, a major influence on the communities residing in the Arab world (Samiul, 2011). Examples of this are found in art, in fashion, and in families with regards to respecting elders and family. Tradition is highly regarded in Arab families and there are some features shared by most Arab groups: the role of the family, class, religious and political behaviour, the standards of social morality

and structure and the economic impact on people's lives, and the presence of change politically and socially (Al-Krenawi, 2014; Kassir, 2006; Nydell, 2012).

Religion plays an important role in Arab culture and identity, which is explained below. It also underpins peoples' characteristics and beliefs concerning life, giving it the greatest influence in shaping peoples' way of living: "Arabs characteristically believe that many, if not most, things in life are controlled, ultimately, by fate rather than by humans. The culture demonstrates that everyone loves children, wisdom increases with age, and the inherent personalities of men and women are vastly different. Beliefs such as these play a powerful role in determining the nature of Arab culture" (Nydell, 2012, p. 67).

According to Encyclopaedia Britannica (2002), the three main religious groups in the Arab world are Islam, Judaism and Christianity. These three Abrahamic religions originated in the Middle East. However, there are other religions followed by minorities such as the Bahá'í Faith, Druze, Yazidism, Mandaism, Gnosticism, Yarsanism, Samaritanism, Shabakism, Ishikism, Ali-Illahism, and Zoroastrianism. Nevertheless, Islam is the main religion in the Arab world, and it is considered the official religion for most Arab countries, with 75% of the population of the Arab nation considering itself Muslim (Encyclopaedia Britannica, 2002).

Islam "سَلَامٌ" is an Arabic word that is derived from "سَلَامٌ Salam", which means peace and purity. As the main religion followed by people from an Arabic-speaking background, it is important to note that an estimated that one billion people from different races, nationalities and backgrounds across the globe are followers and believers in the Islamic religion. Only about 18% of those reside in the Middle East (Encyclopaedia Britannica, 2002). The largest number of Muslims are in Indonesia, some parts of Asia and most of Africa, while there are minorities of Muslims residing in Europe, the Soviet Union, North and South America and China Though not Arab countries, Iran, Turkey and Pakistan are part of the Middle East and their main religion is also Islam (Sorenson, 2008).

As Islam has such an influence within the Arab nation, it is important to know more about Islam and its belief system. Islam is a major world religion with an estimated 1.2 billion followers worldwide. Muslims believe in one God, Allah, who is the same Almighty God as worshipped by the Jews and the Christians. Muslims believe that Allah sent prophets and messengers: starting with Adam, then Moses and Jesus, who they refer to as “Isa”, and Muhammad, the last. Muslims also believe that God sent revelations in the Holy Scriptures including the Torah, the Gospel, and the Holy Qur’an, which is for Muslims the final scripture from God, and was sent to the Prophet Muhammad over 1,400 years ago through the Angel Gabriel. The Qur’an, together with the teachings of the Prophet Muhammad (called the Hadith), sets out the five fundamental practices and duties, which are summed up in five simple rules for Muslims as the five pillars of Islam: 1) Saying the الشهادة shahada (Newby, 2013), which is a declaration of belief in Allah as the one and only God, and in Mohammed as his final messenger; 2) Saying the five- prayer (الصلاة salat); 3) Fasting during the holy month of Ramadan (الصوم sawm); 4) Giving to charity (الزكاة zakat); and 5) Making a Pilgrimage to Mecca (الحج hajj).

Religion has a significant influence on the Arabic language, as the holy Qur’an was composed in Arabic, and the original manuscripts of the holy book are still in Arabic. This is according to the Islamic belief that the holy book shall remain unchanged, and what currently exists around the world in different languages are only translated books of the Holy Qur’an (Faruqi, 1986). An example is the word “Nessa’a”, meaning women, which is merged in the English version of the Qur’an interpretations as below. The holy Qur’an is regarded by Muslims as truly the main source of religion and, as mentioned before, it must only be in the Arabic language. Muslims recite prayers five times a day in Arabic, and the Hadith (meaning), together with all the authoritative source documents for Islamic jurisprudence (Fiqh فقہ) were written in Arabic.

While the text of the original Arabic Qur'an is identical and unchanged since its revelation, there are various translations and interpretations. When a translator translates the Qur'an into another language, they must interpret the meaning and explain it in the new language. As words and ideas cannot be explained identically in different languages, the Qur'an translations may only provide an approximation of the deep, rich meaning that is contained within the original Arabic book. Furthermore, Christian missionaries have written many of the early translations of the Qur'an into English; thus, accuracy or faithfulness to the religious meaning could be inaccurate (Faruqi, 1986), and some translators may simply not have sufficient knowledge of the Arabic language. The current, more reliable English translations are written by Hilali and Khan (1996), Ali, M (2011), Shakir (2001) and Pickthall (1977). Arabic is a very rich language, and some words in Arabic will have more than one meaning. Hence, the wordiness of Arabic and the use of Arabic words to explain in detail very complex ideas, has made the Qur'an one of the richest most meaningful scripts in the world (Faruqi, 1986). It is often quite challenging to get into the deeper cultural nuances of Arabic idioms, and the densities of the words are not easy to understand and translate. The classical Arabic of the Qur'an requires more specialised study in order to fully comprehend the depths of its meaning.

Many people speak Arabic as a native language, and it is considered the official language of twenty countries. The Arabic language is a complex language, and consists of two forms; Fusha and Aammiyya. Hitti (2002) explains it as in his book "History of The Arabs" as a formal language called fusHa (الفصحى) (also known as standard or classical), which everyone learns at school, reads in newspapers, or uses in presentation mode (speeches, lectures, sermons, newscasts, etc.), and an informal language called aammiyya (اللهجة) (also known as colloquial, vernacular, or a dialect), which people use at home and daily life for interpersonal communication, and to express identity, ideas and emotions. Arabic was named the sixth official language of the General Assembly of the United Nations in 1973 (UNESCO, 2017)

and currently, it is the fifth most widely spoken language in the world (Encyclopaedia Britannica, 2002). Going back into history, Arabic originated in the Arabian Peninsula as one of the northern Semitic languages (Nydell, 2012). The only other Semitic languages still in wide use today are Hebrew, which was revived as a spoken language more recently, and Ethiopian Amharic, which branches from old southern Semitic. There are still a few people in Syria, Lebanon and Iraq who speak other northern Semitic languages such as Aramaic, Syriac, and Chaldean (Encyclopaedia Britannica, 2002). Arabic originating from the Semitic languages has historically been considered as mother tongue Semitic, which is the source of the other Semitic languages. the Arabic language was not exposed to any major changes in the Arabian Peninsula; like in Saudi Arabia and Iraq (Ali, J, 1980) where the classical “*fusha*” is still influencing the spoken language.

The use of the Arabic language is somewhat interesting and complex, and there are common linguistic rules that are useful for English speakers to understand. “Arabic shows the fullest development of typical Semitic word structure. An Arabic word is composed of two parts: (1) the root, which generally consists of three consonants and provides the basic lexical meaning of the word, and (2) the pattern, which consists of vowels and gives grammatical meaning to the word. Thus, the root /*k-t-b*/ combined with the pattern /*-i-ā-*/ gives *kitāb* ‘book,’ whereas the same root combined with the pattern /*-ā-i-*/ gives *kātib* ‘one who writes’ or ‘clerk.’ The language also makes use of prefixes and suffixes, which act as subject markers, pronouns, prepositions, and the definite article” (Encyclopaedia Britannica, 2002, para. 3). Many words in English have come from Arabic, such as alchemy, algebra, alkali, alcove, and alcohol. The way to recognise such words is that they begin with “al”, which refers to “the” in Arabic. Many pertain to mathematics and the sciences; medieval European scholars have relied upon and studied old Arabic scholars and their resources, such as “Ibn Alhitham” (Nydell, 2012). The existence of the Arabic language is as old as the Arabs themselves. However, the historical

importance of the oldest Arabic texts mainly concerns the religious Arabic dialects and accents developed in “kindah” (القيده) in the sixth-century pre-Islam, which played a major role within the old royalty and poetry. Taking a more general view, there is no doubt of the critical role the Arabic language plays in understanding the Arabic world, particularly in the way that it influences how people respond to both the Qur’an and the Hadith, and how that is interpreted and played out in their everyday lives.

As explained before, the Arabic language is classified into two major categories; Classical (الفصحى fuṣḥá), Modern Standard and Spoken Arabic (aammiyya); most religious and educational institutions use Classical Arabic, and it’s the official language of the Arab world. Also, the Qur’an is written in Classical Arabic. However, Modern Standard and Spoken are most commonly used by most Arabs, who speak it in their own dialect.

The Arabian Peninsula is important to the Muslim world and to other Arab countries. لاجاز Alhijaz, the birthplace of Islam (Hitti, 2002) and currently a region in the Kingdom of Saudi Arabia, had a profound influence and effect on history and the development of Islam in the 18th century when a religious scholar of central Najd, Muhammad bin Abdul Wahhab, joined forces with Muhammad bin Saud, who was the ruler of the town of Diriyah (located in Saudi Arabia now), to enforce Islamic order and unite the Arab tribes, starting from Najd region and gathering up the rest of Arabia (now Saudi Arabia) (Wynbrandt, 2010). The Kingdom of Saudi Arabia is seen by many as the heartland of Islam, the birthplace of its history, the site of the two holy mosques and the focus of Islamic devotion and prayer. Saudi Arabia also professes its commitment to preserving the Islamic tradition in all areas of government and society. Islam has a strong influence not only on the lives of its people but also on the policies and structure of the government. The Holy Qur’an is considered the constitution of the Kingdom and Shari’ah law—Islamic law—and it is used in the Saudi legal system (Vogel, 2000).

It is also obvious that this comprehensive adherence to the Arab identity also inculcates a dominant political, cultural and ruling presence and influence. This is evident in many political and cultural processes and in documentation across the globe. According to the Saudi Arabian Embassy in Washington, DC, “Saudi Arabia is a leader in the pursuit of worldwide Islamic solidarity. It hosts the Muslim World League and the Organization of the Islamic Conference—institutions dedicated to preserving Islamic interests. In many respects, the Kingdom has been responsive to the needs of the Islamic world. Saudi Arabia contributes generously to the *Islamic Development Fund*, which aids with community infrastructure projects; to the Islamic Development Bank, headquartered in Jeddah; and to the Islamic Organization for Science, Technology and Development. Saudi Arabian leaders also work tirelessly to promote peace and stability in Muslim and Arab countries and throughout the world.

This summary about Saudi Arabia is intended to provide an understanding of the majority of the research participants, as 80% of the participants were from Saudi Arabia.

2.6 Political and cultural history of the Arabic-speaking community in Australia

The first generation of post-colonial Australians contained the highest proportion of people who spoke a language other than English at home (53%). For recent arrivals, the languages spoken at home varied from those spoken by longer-standing migrants to those used by the overseas-born population. More than 60% of newly arrived migrants spoke a language other than English at home; Mandarin (10.8 %), Punjabi (3.7%), Hindi (3.3%) and Arabic (3.0%) (ABS, 2016). The census held in 2016 revealed that Arabic is now the third most-spoken language in Australia, with 321,728 (1.4%) of the population speaking it as a language other than English at home.

2.7 History Arabic-speaking community in Australia

Long ago, before the arrival of the British colony, the Australian Indigenous population was in constant contact with foreigners of Muslim and Arabic background due to trade and commodity

dealing with Indonesia and other countries; still today, some Aboriginals follow the Islamic beliefs as a religion (Stephenson, 2011). Ganter (2008) mentions that the trade boats of Wareham Island, north of Australia, are living proof of the existence of Islam on the island, which may be a different story to what the average Australian knows today. These traditional Indonesian boats were known as “Braus”, and some of the traders and fishermen from Makassar who travelled on these boats settled in Australia and had some religious and cultural influence in some areas. Many of these traders and fishermen were Muslims, and some of them had an Arabic background from Yemen (Macknight, 1976). Some historians believe that they arrived in Australia in 1750; however, it is argued that some drawings or parietal art were completed before 1664, and probably date back 1500 years (Ganter, 2008). Today, there is a growing number of indigenous people who convert to Islam (Stephenson, 2011), and for many indigenous communities, Islam is an extension of their cultural beliefs. According to the population census in Australia in 2011, there were 1140 indigenous people who identified themselves as Muslim, which is less than 1% of the total number of indigenous people in Australia.

After World War II, many people from the Arab world started migrating to Australia where some communities, such as the Lebanese and Egyptians, were already established. The Lebanese migrants came to Australia in the late 1880s, then the second wave of migration happened after the Arab-Israeli war of 1967. Then in 1976, migrants started fleeing the civil war in Lebanon. Many of them were Lebanese Muslim families who were humanitarian entrants (Hage, 2002). Many people in Australia may defend themselves as Australian Arabs, but without understanding the complexities of the way people identify themselves, it is notable that the wider Australian society does not “often make such fine distinctions about ethnic identity among people they label as ‘Arab’ or more broadly ‘Middle Eastern’”. The AHRC states

that some Australians see Persians, Afghans or Turks as ‘Arab’ and may discriminate against them on the basis of that perception” (AHRC, 2017).

2.8 Countries of migration

According to the Australian Bureau of Statistics consultancy service report (ABS, 2016), the only available comprehensive resource, most Arab migrants’ country of origin was either Lebanon (71,349), Egypt (33,432) or Iraq (24,832). Of these, 89,021 had a Lebanese-born parent, and 10,296 had an Egyptian-born parent. The ABS 1995 Year Book states, “Arrivals from Lebanon (68,787 first- and 67,453 second-generation in 1991) may be Catholics, Orthodox, Shi’a Muslims, Sunni Muslims, Druze or Armenians, each with differing loyalties and orientations”.

Chapter 3 explains more of the theory behind migration it. However, some of the major factors contributing to Arabs seeking humanitarian aid from or migrating to Australia or other developed countries such as the United States of America and the United Kingdom, as their struggles with social and psychological difficulties (Al-Krenawi, 2005) and injustice due to the current Middle East wars, poverty, human rights violations (Hage, 2002) and unemployment (Salloukh, 2013). An example of this is the Iraqi migrants, both Muslim and Christian, who fled the ruling of Saddam Hussein, and those who sought asylum following the ISIS invasion of Iraq. It is “common for minorities to emigrate, often to escape persecution. Only a handful from Iraq is Arab Muslims, while the great majority are Christians” (ABS, 1995).

There was a rapid increase in the number of Arab migrants coming to Australia from different countries to enrol as international students in the six years prior to 2012 (Shepherd & Rane, 2012). What was only a few hundred in 2006 increased to over 12000 by the end of 2009, and to over 13000 in 2012 (Austrade, 2012; ABS, 201). Some international students from Arabic countries may live in Australia to study and then return to their home countries,

and some may decide to stay after finishing their studies and use this qualification as a mean to settle in Australia (Al-Krenawi et al., 2009).

The Australian Bureau of Statistics (ABS) has stated that “the majority (85%) of Australians born in Arab countries have become Australian citizens. The citizenship take-up rate for overseas-born Arab Australians varies according to birthplace and is highest for longer-established groups”. (p.211)

Nonetheless, for people from Arab countries, the difficult experiences and stressors they may have had or are still encountering, or previous choices they have made, may be push factors for migration. This is discussed in Chapter 4.

2.9 Culture: Language and Religion of Arabic speakers in Australia

The Arabic-speaking population represents 1.4% (280,000-350,000 people) of the total Australian population (ABS, 2016). The Arabic-speaking communities in Australia are diverse and include people from 22 countries, as mentioned earlier. The number of people who speak a Language Other Than English (LOTE) in Victoria is 23.1%. It is reported that 5.5% of those are Arabic speakers (ABS, 2016). People will be identified as Arab if Arabic is their main language, or it is spoken by a significant portion of the population of their country of origin.

The Australian Human Rights Commission created a project aimed at eliminating prejudice against Arab and Muslim Australians, which was launched by acting Race Discrimination Commissioner, Dr Bill Jonas, in Sydney on 21 March 2003 to coincide with the International Day for the Elimination of Racial Discrimination. The project (Isma "السمع" - Listen) was a national consultation on eliminating prejudice against Arab and Muslim Australians, and its aim was to restore and maintain harmony in the Australian community at a time when negative feelings against these groups may have arisen. The project was designed to enhance public awareness about Arab and Muslim Australians; encourage opinion leaders and community

organisations to demonstrate solidarity with Arab and Muslim Australians against racist attacks; ensure that Arab and Muslim Australians, and other targets such as Sikhs, were not isolated but could continue to participate fully in society; empower communities to ‘speak back’ to ensure that Arab and Muslim Australians were heard on issues affecting them; ensure that complaints about discrimination and vilification were treated seriously; and challenge vilification, discrimination and stereotyping (AHRC, 2017). The report of this project was a very valuable resource that identified basic, important information about Arab Australians.

According to the 2016 Census, 2.6% of the total Australian are Muslims -604,200 people- but not all of them were Arabic speaking. In addition, despite the fact that most Arab countries are Muslim (Faruqi, 1986) leading to the assumption that all Arabs in Australia are Muslim, a large proportion of Australia’s Arabic community is Christian; for example, 55% of Lebanese-born Australians and 84% of Egyptian-born Australians consider themselves to be Christian (ABS Census, 2001). Islam and Christianity are the two main religions Australian Arabs follow. Around 1.5% of the total Australian population might use terms like ‘Muslim Australians’ or ‘Australian Muslims’, but it is merely used to identify Australians who are followers of Islam. All Muslims who live in Australia, including those with temporary resident status, might be included in this group definition (ABS Census, 2016).

2.10 The Arabic-speaking community in Victoria and their demographic information

The state of Victoria has many diverse communities that have come from 200 countries around the world. They speak 260 languages or dialects, and they reside in 135 different regions. Arabic ranks as the sixth most common language spoken at home and accounts for 5.5% of the language other than English (LOTE) spoken at home (VMC, 2017).

In 2001, the demographic make-up for Australia was very similar to the demographic make-up of Victoria’s Arabic-speaking community. The number of people born in Egypt was higher than the number of people born in Lebanon, and Australia-wide there were substantial

populations of Arabic speakers born in Sudan, Jordan, Kuwait, and Gaza Strip and West Bank, but the populations of these groups living in Victoria were not large. While the group born in Eritrea was also quite small, two-thirds of the group lived in Victoria.

Most of the Arabic-speaking population in Victoria are Muslim. There are also several Christians, particularly among the Egyptian-born community, who are largely Coptic (The Coptic Orthodox Church is one of the earliest Christian churches). Other religions include Catholic, Orthodox Christian, Chaldean and Maronite (VASS, 2017).

The largest community groups from Arab countries that now live in Victoria originate from Egypt, Iraq, Jordan, Lebanon, Palestine, Somalia, Sudan and Syria. There is significant religious, ethnic and linguistic diversity in every single one of these communities. Figure 2 shows the numbers within the community groups in Victoria and a detailed table can be found in Appendix 3:

Country of birth	Number
Lebanon	71 349
Egypt	33 432
Turkey	29 821
Iraq	24 832
Iran	18 789
Syria	6 710
Israel	6 574
Other Middle East	13 212
Other North Africa	8 918
Other not further defined	303
Total	213 940

Figure 2. Community groups from Arab countries living in Victoria (ABS, 2011)

The ABS Census in 2016 showed that Arabic was spoken by a total population of 287,174 people, which represented about 1.3% of the entire Australian population. Growth has been observed in the number of Arabic speakers since then, who now represent around 1.4% of the

population (ABS, 2016). A large proportion of the population of Arabic speakers who are residing in Australia are from Middle Eastern countries, some Arabic speakers are Australian born, and the rest are from West and North Africa. Overall, 4.4% of overseas-born Australians are Arabic speakers, as reported by the ABS (2016).

The largest proportions of Arabic speakers in Victoria are from Lebanon (27.5%), and Lebanese make up 30.9% of the total number of Arabic speakers in the country. Most Egyptians whose first language is Arabic reside in Victoria, where they represent 10.9% of Arabic speakers. Arab speakers with Iraqi origins sit at 7.9% in Victoria, while their total number in Australia makes up 5.2%. Those of Kuwaiti origin represent 1.6% of Arabic speakers in Victoria and 1.0% of the entire Australian population. Sudani Arabic-speaking migrants in Victoria represent 1.7% of the total Arabic-speaking population, and their entire population in Australia is 1.9%. Arabic is one of the most-spoken languages among the non-English speaking groups, as it has increased by 18% in Australia and 13.5% in Victoria since previous years.

The 2015 census (ABS, 2016) showed that around one-third of Australian Muslims, live in Victoria. Not all the Arabic speakers are Muslim, however, as only 42.8% of the Arabic speakers originally from Lebanon are Muslim, as are 40.1% of the Iranian Arabic speakers. In recent years, lower numbers of Lebanese immigrants who are Muslim are recorded; for example, 550 Muslim Lebanese in a year. The ABS reports that the increase in the size of the Islamic community is not caused by immigration, but is rather from the birth of children into Muslim families already in the country. The female gender is slightly better represented in Victoria than its male counterpart, registering 50.9% and 49.1% of the total population, respectively, according to the ABS census (2016). Of the total Arabic speakers in the country, males comprised 50.8% to 49.2% of female Arabic speakers, showing that there are more male Arabic speakers than female Arabic speakers in Australia.

The arrival of Arabic-speaking people in Australia, especially from the Middle East, has been stable since 1992. This has been a result of the Australian Government easing entry restriction rules during the outbreak of civil war back in 1975, as reported in the Department of Immigration and Citizenship's (DIAC) Community Information Summary for Lebanon. The Gulf War in Iraq has seen the number of people born each year in Iraq since 1991 to rise from 825 to 2,594 people per year.

In general terms, Arabic-speaking immigrants have a low level of educational qualifications, which is confirmed by a whopping 55.9 % of the entire Arabic-speakers' population in Australia. As most of the Arabic speakers are from Lebanon, Lebanese with a lower level of academic qualifications comprise 34.2%, while others from the rest of the world make up 43.2% (ABS 2017). However, the proportion of the level of education of Australians born in Arab nations is similar to that of all Australians. Around (13%) have a bachelor's degree or higher qualification. Fewer Arab Australians (15%) have a diploma or certificate compared with all Australians (22%), and a higher proportion of Arab Australians (8%) did not go to school compared with all Australians (1%).

Arabic speakers are scattered all throughout Australia. Victoria, as one of the states with the highest population of Arabic speakers (56,000), has found them to have spread to locations such as Banyule, Brimbank, Casey, Darebin, Hobson Bay, Maribyrnong, Yarra and other places in Victoria. From the census results, we can, therefore, conclude that not all the Arabic speakers in Australia are Muslims. This is confirmed by the 57.2% of Lebanese Arabic speakers who have immigrated to the country who are not Muslims. Further, the results confirm that the rise in numbers in the Islamic community is due to children being born to Muslim residents, and not due to immigration as may have been thought. Additionally, the Arabic-speaking community represented 1.4% of the entire population in Australia in 2017.

The represented statistics indicate the growing need to better understand the background and the historical, cultural and political complexities of the Arab-speaking community- and particularly in relation to how services and policies can best sustain and respond to this growing demographic in Australia and particularly in Victoria.

There are many social services that offer support to CALD communities, such as the Ethnic Communities Council of Victoria (ECCV) and others, depending on the need of the individual and their region. However, there are two primary, well-established social service providers in Victoria that particularly provide service to the Arabic-speaking community. The first is Arabic Social Welfare Incorporated, located in Moreland², which provides customised services to educate, support, advocate on behalf of, and encourage the autonomy of the Arabic-speaking community through offering a range of services, groups, workshops and programs. It also has a website, ArabiCare, which states:

The ArabiCare website provides useful information to support increased understanding and effective engagement with diverse people of Arabic-speaking backgrounds. You will be able to find information on various subject areas relevant to community members of Arabic-speaking backgrounds in Australia, including their history, language, customs and traditions, diverse religions, diverse ethnicities, migration and community profiles. While the website has a primary focus on service providers, it also offers useful information to all community members who are interested in understanding Arabic culture and the values and beliefs which are important to Arab Australians and the diverse ethnic groups who have migrated from the Arab world. (ArabiCare, 2017)

²Moreland is a municipality in the inner north of Melbourne, in the state of Victoria, Australia

The second provider is Victorian Arabic Social Services (VASS), which is an incorporated, not-for-profit association that provides support to people from Arabic-speaking-background communities in Victoria. They provide a range of support, including counselling, casework, referrals, advocacy, community development, mediation, and social, cultural and linguistic support to people of Arabic-speaking-background communities, and other culturally and linguistically diverse communities. They are located in Broadmeadows, Fawkner, Dandenong and Newport, which are the suburbs with the largest number of Arabic-speaking people in Victoria (VMC, 2017).

Literature Review

Chapter 3: Epistemology, methodology and methods

3.1 Introduction

This chapter explains the methodology and research design used to answer the research questions presented in Chapter 1 and explore mental health literacy in the Arabic-speaking community in Victoria, Australia. It draws on a community-engaged research design and methodology that has been used in other community-based research (Ahmed & Palermo, 2010; Broussard, 2011; Mulligan & Nadarajah, 2008; Nadarajah, 2005). This research methodology shares some principles of action research such as involving the researcher as part of the data collection but differs in that it sustains a clear distinction between the knowledge and skills of “outside” researchers and the hard-won local knowledge of community members (Nadarajah,

2005). When I first commenced drawing up this research, I was always aware of research subjectivity, and how I, as a researcher, had to take a step back and observe. I could not help but notice that separating myself from the research and, hence, the community, was an authentic way to understand. After all, I am a practitioner and worked for some years very closely with my community. I also have my own personal stories that I believe will add strength to this research. I was sure that the best way to collect accurate and authentic data was through engagement with my communities' life stories, which in many occasions through the interviews had been intertwined.

This methodology involves a careful integration of quantitative and qualitative methods, and the suggested data collection methods for this research—quantitative and qualitative—will assist in identifying relevant information to explore further. It will also help complement the needs of culturally sensitive areas of research, where one method of data collection might not be effective and may not harvest the deep understanding required. This is in line with the view expressed by Jason and Glenwick (2016) that “using both quantitative and qualitative methods in a single study can address and combat each other's strengths and weaknesses”(p 236). Hence, community-engaged research is the framework that will inform the data collection and anticipated outcomes and is the overarching design for this research and the data collection methods. The three methods of data collection explained next in this chapter are as follows: 1) The advisory community expert group; 2) The short online surveys with multiple choice and open-ended questions; and 3) Face-to-face interviews.

This chapter describes the methods and the data collection process which draws on community-engaged research and grounded theory whilst employing autoethnography as a reflexive process that can be used further to analyse the data and to arrive at the findings.—This methodology has helped not just me, but also the community (both online and face-to-face) to reflect on and explore their own ideas and experiences while providing a culturally appropriate

platform, suggesting positive steps towards fighting stigma, and exploring our own understanding of mental health literacy within our cultural context and in the wider Australian environment and regulations this will be presented in Chapters 6 and 7. At the same time, I had been reflecting on my own position, theoretically, personally and culturally. Khawaja and Mørck (2009) state, “The concepts of otherness and othering describes the power-relational process based on the fundamental positioning of oneself as different from the “other” in regard to existing discursive norms and categories that are perceived as universal and natural” (p.28). Researching “the other” in my own community calls for close reflections on my own position as an insider, and after collecting the data and being able to see the rich and amazing stories and narratives unfolding both through the surveys and the interviews; it was important to address the idea of objectivity, and not including my own narrative, progress and growth through this, as an insider and a practitioner. Many of the stories and narratives and anecdotes relating the participants lived realities or experiences resonated so much with the stories and narratives that I too had grown up with; and continued to hear as part of my own professional experiences and work in the area of mental health. It was important for me to ground my own experiences and examine them in a structured way in this thesis – and particularly in the analyses. In my discussions with supervisors and in reading through my research methodologies; I found the best way to integrate and locate myself in this research was through “autoethnography”. Previously I have discussed this in ~~more~~ detail in Chapter 1 section 1.10. However, the next section explores community-engaged research, autoethnography and grounded theory in more detail.

3.2 Community-engaged research and grounded theory

Community-engaged research is explained by Mulligan & Nadarajah (2008) as “a considerable advance over most forms of action research because it clarifies the distinct role of researchers and community members in the creation of mutually beneficial research partnerships” (p.92).

It has been identified by some scholars as one of the most commonly used research approaches in health and social research, as Ahmed and Palermo (2010) confirm; it helps “enhance a community’s ability to address its own health needs and health disparity issues while ensuring that researchers understand community priorities” (Ahmed & Palermo, 2010, p. 1).

Community-engaged research has similar aspects to participatory action research, which is defined as a:

... participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory worldview [and bringing] together action and reflection, theory and practice, in participation with others in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and communities. (Reason & Bradbury, 2001)

However, some scholars refer to community-engaged research as a type of participatory action research (Ahmed & Palermo, 2010; Baum, MacDougall, & Smith, 2006) as they both highlight the participation between the community or research participants and the researcher, with the goal of understanding and observing problems with the intention to empower the community members to create solutions to those problems (Chevalier & Buckles, 2013; Kindon, Pain, & Kesby, 2007).

Where they differ is in regards to sustaining a clear distinction between the knowledge and skills of the researcher as an insider-outsider (Mulligan & Nadarajah, 2012) and the local knowledge of community members. Reason and Bradbury (2001) note that participatory action research has a major collaborative dynamic, which gives the participants an equal part in working as co-investigators, when they say, “Communities of inquiry and action evolve and address questions and issues that are significant for those who participate as co-researchers”.

Participatory action research is an expression of “new paradigm science” that differs significantly from old paradigm or positivist science (Swepson et al., 2003; p. 250). According to Stringer (2007), integrating the researcher into any given community research through the use of relevant skills or knowledge -according to community-engaged research (Mulligan and Nadarajah, 2012)- will enable the researcher to be actively action-oriented. Relevant skills or knowledge cover areas such as interpersonal skills, cultural competency, group facilitation skills, consensus building, research skills, knowledge of service-delivery systems, awareness of the community processes, awareness of power and authority in the enquiry, and an understanding of the economic and political systems affecting the community of enquiry.

The main idea behind using community-engaged methodology in this study is to emphasise participation between the researcher and the community while seeking to gauge and understand mental health literacy and trying to improve it, both collaboratively with community reflection and from the researcher’s observations.

The Arabic community who may experience/observe the level of mental health literacy are in the best position to work with the researcher to address any issued that might arise. Participants can establish equal partnerships with the researcher, which will help to address the community needs and perspectives. The community-engaged research activities and data collection methods such as the advisory group and the face-to-face interviews will help to empower members of the Arabic community, who are considered as a culturally and linguistically diverse community with different sets of beliefs. The community engagement that takes place during the process is a critical part of any suggested outcomes, recommendations or invitations for future studies.

Community-engagement research typically focuses on social change according to the community’s best interests and views, which is an outcome of exploring the way of thinking around mental health issues, and helping to elevate the stigma around such issues (Al-Krenawi

& Graham, 2000a). However, the results will not only be a collective vision but will also provide a strengthening sense of community, which will assist the processing of ideas, beliefs and perceptions of mental health at the intellectual, social, cultural, and emotional levels. This will help me to understand the experiences and cultural perceptions of the Arabic community outside the host culture, Australia (Jason & Glenwick, 2016). Community-engaged research helps researchers to become part of the community and community members to become part of the research team, creating a unique research and learning atmosphere (Ahmed & Palermo, 2010). In the case of this research, it also helps the researcher in working with more insight and understanding with the one-to-one interviews, particularly as individuals are also closely linked to their communities in many ways. As Chapters 1 and 2 have indicated, the cultural, political, religious and historical complexities of the Arab-speaking communities are so closely integrated or linked with their communities where they come from.

This research employs aspects of grounded theory because it will draw knowledge from community-based interaction and observation. Using community-engaged research will help to identify the issues, plan the inquiry, and involve the panel again to analyse results with the help of the community (Jason and Glenwick, 2016), which is explained further in section 3.3 Research Design. Grounded theory helps in developing a new theoretical framework to describe this research. It will also assist later by providing coding techniques for data analysis. This research will use a more constructive approach to grounded theory following that used by Charmaz (2006), as there is more focus on context and complexity, and it is not as procedural as the approach used by Strauss and Cobin (1967). The context and complexity of mental health issues will need cooperation and co-construction of the inquiry at hand when it comes to mental health literacy, as the question is asked how do people draw on “socially constructed discourses” (Charmaz 2009, p.142) and how does the Arabic-speaking community understand mental health literacy? Furthermore, it will help me as a researcher, and a member of the

Arabic-speaking community and as a mental health professional, to form a better understanding of mental health literacy together with the community. Constructivist grounded theory will also allow me the possibility of investigating multiple meanings and multiple theories around mental health. A further explanation of grounded theory and the application of community-engaged research in thesis research has been explored in Chapter 1.

Using community-engaged research and grounded theory side by side has helped me to conduct a much deeper and thorough exploration, observation and summary of what questions need to be asked of the broader community through the online survey. For the analysis, and after gathering the data, I have used autoethnography as a method, which will be explained in this chapter. Drawing on the concepts of community-engaged research in data collection, the online survey, and as I aimed, has given the community the opportunity to answer questions with the reassurance of remaining anonymous, which also encourages honesty (Wright, 2005), while providing insightful information for my observation and investigation. After further analysis, the answers collected from the online survey have led to forming further questions for the face-to-face interviews, which was prepared by reflecting on my experience working as a mental health professional and practitioner, and with the experts' advisory group and on my professional work history as a mental health bilingual educator. The available literature combined with the knowledge of the community-research participants, the advisory members, participants in the online survey, and the interviews have helped me to identify existing theories and propose new ideas and recommendations about existing problems concerning mental health literacy, and have definitely helped to inform data collection and analysis methods. Additionally, the findings may generate possible solutions to address any arising problems identified through the data collection, which I am anticipating ~~hoping~~ will lead to better understanding and raise awareness of mental health, and diminish the stigma surrounding mental health issues in the Arabic-speaking community.

3.3 Autoethnography

This section highlights autoethnography as an additional approach to understanding and acting as an “insider-outsider”. I define autoethnography and explain why it is useful to this research. Thus, I often asked myself, starting this research, *how much do I know about the Arabic community of Victoria?* About my community, and how being an insider is good knowledge, I asked myself, what is “enough” knowledge and is it a negotiable measure of the self, of the community? As an insider I am part of this research, as Clandinin and Connelly (2000) posit;

I did not enter the field to gather research data. I am in the field, “a member of the landscape”. (Clandinin & Connelly, 2000, p.63) as cited in (Trahar, 2009) [7]

Looking at the literature (Al-Krenawi, 2014; AlMunajjed, 1997; Hammad, Kysia, Rabah, Hassoun & Connelly, 1999) and observing my community, including myself as an Arab woman, led me to understand that we share some values, some cultural understandings, hence, differ significantly in many layers. Understanding these layers, understanding the cultural richness and understanding myself, as part of the community, and as a practitioner and a helper for many of them have paved the road for an autoethnographical lens for observing this research. Therefore, autoethnography represents the relationship between “the observers, observational methods and the observed” (Brodkey, 1994, p. 30). It has also been explained as “An approach to research and writing that seeks to describe and systematically analyse (graphy) personal experience (auto) in order to understand cultural experience (ethno)” (Ellis, Adams, & Bochner, 2010. Para1). Other scholars define it as “... a form of self-narrative that places the self within a social context. It is both a method and a text, as in the case of ethnography”(Reed-Danahay, 1997, p. 9). It was also defined as an approach that “uses a researcher’s personal experience to describe and critique cultural beliefs, practices, and experiences” ... “acknowledges and values a researcher’s relationships with others”... “uses deep and careful self-reflection”(Ellis et al., 2010, p. 2). According to the Dictionary of Human Geography

(2013), autoethnography is “a form of ethnography that is highly self-referential wherein the researcher is partially the focus of analysis. Like ethnography, autoethnography involves participant observation and embedding within a community; however, the division between ethnographer and community is blurred with the researcher writing autobiographically about their experiences, ethnographically about their own culture and their place within it, or about their experiences of being the subject of an ethnographic project. It is a reflexive approach aimed at exposing the positionality of the researchers and situatedness of the analysis” (Castree et al., 2013a, p. 26).

Ellis and Bochner have been two of the pioneers in exploring the approach through personal narratives and reflectivity, challenging traditional social research approaches. Early 1990 and after formulating a study in the handbook of interpersonal communication – as a student themselves – they were trying to move away from the traditional way in social research “logical positivist” and the laws of social behaviour and generalisations but rather the whole process of creating meaning in social life. They started developing ideas through studying the work of the philosopher Richard Rorty in the mid-1980s in which he developed a pragmatist orientation towards social inquiry. Researching in fields like mental health with multicultural communities, or within intercultural studies, will not have a recipe for understanding; it will have complex, challenging stories and “meaningful phenomena that taught morals and ethics, introduced unique ways of thinking and feeling, and helped people make sense of themselves and others” according to Ellis, Adams and Bochner (2010). Undoubtedly, researching mental health literacy and trying to understand my community –myself- requires a great deal of a pragmatist observation to way of understanding the social context, as a partitioner, as much as being part of the community; while embracing all the thoughts, the stories, the feelings and the deep level of awareness that is rarely discoverable on the surface when humans are treated as

objects in research. The value of interacting with the community, sharing our stories through narrative indeed had offered me a greater insight into my community's perspectives.

This research design draws upon cultural perspectives and understanding, employing various social research theories such as grounded theory, transnationalism and some aspects of community engagement. However, autoethnography strategies have been developed and applied by many scholars, including Ellis, Adams and Bochner (2010), Besio (2009) and Denshire (2014), who highlight it as a way of understanding and researching communities. The methodological approach developed by these scholars has helped me shape my enquiry and my practitioner's experience in a clearer approach; enabling me to remain open to my community, and to explore and challenge my own thinking using "critical reflexivity" (Zempi, 2016), while finding new ways for conducting "intercultural" research along with my own experience, rather than stepping aside, and diminishing our mutual cultural knowledge. This concept could be described as "the walking along" with the community as Boulet (2018) explained "the etymological origins of the word 'method'; it derives from the Greek *μετα ὁδός* (meta hodos) or '*being on the road*'; so, social research could be understood as '*being on/walking along a more or less deliberately chosen road whilst relating/conversing with 'others' and with the landscape together traversed, with more or less defined (mutual) purpose(s)...*'(p130). With logical positivist research, we could easily disregard other ways of understanding. Besides, traditional positivist approaches imply that other approaches of research are invalid or could be unsatisfactory. On the other hand, autoethnography "expands and opens up a wider lens on the world, eschewing rigid definitions of what constitutes meaningful and useful research" (Ellis et al., 2010, p. 275).

Using autoethnography have helped me to highlight the division between myself and the community when the research boundaries become blurred. Moreover, it also helped me as a practitioner/researcher to write autobiographically about my experience, and ethnographically

about my own culture and my place within it. Autoethnography is a reflexive approach, and it was a way for me to fill some gaps between being a researcher at the same time being part of the community I am researching.

Autoethnography is not a new research approach; Lakey, E. an RMIT alumni, did an autoethnographic study about the Somali community in Melbourne. Hence, her position as an outsider has inspired me to research mental health literacy by linking my life's work and my life in Saudi Arabia with the participants' narratives, views and perceptions about mental health literacy. Other RMIT alumni like Lines (2005) in a PhD thesis examining and understanding change within universities systems, also Murray (2009) titled Analysis of professional practice of being an indigenous cultural awareness trainer.

Nevertheless, as much as autoethnography is valuable in my research, it has been criticised by some hypothesis-testing, theory-driven scholars who practice positivist epistemology in research. In her article, Delamont (2007) claims how "lazy" Autoethnography is, and while reading a few studies I could not help but wonder how much effort is invested in this approach to identify, theorise and to understand the community, rather than having a shallow understanding of the community (Jones, Adams & Ellis, 2016). Delamont (2007) claims that autoethnography "focuses on people on the wrong side Autoethnography focuses on the powerful and not the powerless to whom we should be directing our sociological gaze" (p2). It comes to my mind all those people who I felt "powerless" about what they felt as they talked about "Iktea'ab بحزن" ³ –as a trained counsellor and mental health educator- how can I be objective about my wondering empathy and how do I dismiss the "Hozzn حزن" ⁴ some of the communities' spoke about when dealing with mental health with loved ones, and how they felt

³ Iktea'ab بحزن Sadness and depression

⁴ Hozzn حزن : deep utter disabling sadness

powerless with those feelings; in which I lived through in my teen years with a loved one living in Saudi Arabia.

It is argued by Ellis (2010) that “those who advocate and insist on canonical forms of doing and writing research are advocating a White, masculine, heterosexual, middle/upper classed, Christian, able-bodied perspective” (p. 275). It makes me respectfully acknowledge and question what critics like Delamont (2007) are claiming. I am a Middle-Eastern woman, and that will not change, nor the fact that I am part of a minority in Australia; therefore, does my existence count in this research, or will my background dismiss my knowledge? And why would working and “walking with” my own community be considered bias? Why have researchers working within their own communities been accused of such a thing? And why would the same accusation not be made toward “white” researchers (Jorm, Wright & Morgan, 2007; Reavley & Jorm, 2011) working with white populations, nor toward “White professionals working with racial and ethnic minority populations?” (Dwyer & Buckle, 2009, p. 61). So many questions made me think and acknowledge researching my community while keeping this research unbiased.

When I came to study autoethnography further, I found that I am “allowed” to embrace—and foreground on subjectivity, using careful skill to remain aware of my ‘meanings’ and distinguish them from those expressed by the research participants (Voloder & Kirpitchenko, 2016). I was skilfully cautious and restrained while collecting data and observing this research unfold, as I did not want to spend my research journey “obsessing” about my objectivity, as Delamont (2007) uncompromisingly argues. I found in autoethnography a skilful strategy of combining a committed “self-reflexivity with an autoethnographic sensibility” (Besio, 2009, p. 242) which gives room for more complex analysis and representation of my community. With this approach, I was honoured to be listening to and sharing the narratives that my community hold toward mental health, which created an intercultural space for them and myself to “co-

produce knowledge” (Besio, 2009, p.243). This allowed me to reflect and use reflexivity, in pursue of an ethical and transparent approach to understanding and researching mental health literacy in my community. I cannot help but to “feel” the stories of my community; which for me is an ethical issue and a constant reminder of why I am doing this and why it matters, as I explained in Chapter 1. Our experiences and struggles with mental health literacy are very similar, hence, as researcher, I am part of what I am studying, and my community are “re-imagined as reflexive narrators” (Besio, 2009, p. 1600; Butz & Besio, 2009) of my research.

This research started with so many ideas and so many thoughts. I had to be “enlightened” by the culture of social research where it is expected that you “should” take an observatory stand, no engagement, no opinion. So in autoethnography, I had a space to understand and locate myself and how my community perceives me, and where that fits in this research and its findings, or as Ellis et al. (2010) beautifully illustrate, “this approach also helps understand how the kinds of people we claim or are perceived to be influence interpretations of what we study, how we study it, and what we say about our topic” (web, para. 4).

Autobiography could be present in many autoethnographic illustrations. Moreover, autoethnography offers the skill of exploring “Beyond the writing of selves” (Denshire, 2014, p. 833), which is the line that I had to observe- as a researcher- relentlessly and reputedly between personal and professional life spans. There was this fine line that I observed between listening to the community’s’ stories and living many of these experiences myself, not forgetting the aspect of working with them as a practitioner and studying mental health for some years. This crossing goes beyond autobiography, where researchers have the relentless space to “critique the depersonalising tendencies that can come into play in social and cultural spaces that have asymmetrical relations of power” (p833) as Denshire (2014) states. In the next section, the research process and design will be further explained while highlighting the data collection methods.

3.4 Research Design and triangulation

This research is focusing on understanding mental health literacy the Arabic-speaking community of Victoria, the design of the research is based not only on the theoretical or clinical studies, but also on community-engaged approaches, due to the scarcity of theories investigating mental health literacy in non-English speaking communities as it is a culturally sensitive area of research (Shameran Slewa-Younan et al., 2014). Grounded theory is the appropriate approach because the study design and choice of methods have proven effective in drawing theories from the data analysis. Grounded theory is a way to work with what is gathered from the field, which enables the construction of findings and/or theoretical contributions through the process of analysis. A more in-depth exploration of grounded theory is found in Chapter 1, Introduction. Autoethnography was also utilised, as it started surfacing while I was collecting the data, due to the shared experiences and relationship with the community. There are two groups of participants on two phases of data collection, as mentioned before in Chapter 1.

3.4.1 Advisory Group members

I had been diligent in collecting data from community members per the work I do with the Ethnic Council of Victoria, the Arabic social welfare and the transcultural mental health, St. Vincent hospital. Ten experts from these organisations were engaged as the advisory group for this research, and expert insight has confirmed, informed and helped the data collation processes. The information and insight gathered from them, do set as “data” of some kind. It has added depth and clarity to the understanding of mental health literacy in the community.

The knowledge, experience and qualifications of these group members are invaluable. Contacting them was done based on the advice of the supervisors, from online research and following recommendations from members of the Arabic community. The advisory group was a useful way to gain insights from experts concerning the Arabic community. Thus, the

available literature on mental health literacy and the key ideas provided by this group of experts have helped to inform the questionnaire for the online survey, which has led to the interview questions.

Key people for the consultation regarding the research directions and questions were recruited, drawing upon the researchers' networks within the Arabic-speaking community of Victoria. This advisory group provided input and feedback throughout the project. As access to literature and materials about mental health literacy in the Arabic community in Victoria is not widely available, and given that mental health literacy is generally a new area of research (Jorm, 2012), the community experts advisory group consist of service providers with lived knowledge and experience in the field of the Arabic-speaking community, and its culture and issues, through their professional roles. This group of experts in the field are from an Arabic-speaking background, have a passion and interest in building community capacity in health and wellbeing, and have a genuine desire to help due to their previous experience working in the area. As Nadarajah (2005) has stated in her article on *Community and Spaces for Engagement* "People take part not because they have to, but because they want to work together for a better future" (Nadarajah, 2005, p. 14).

Reference groups or project advisory in research, are set up to advise on a specific research task, view and/or methods in general (Chevalier & Buckles, 2013). They are often small groups of four to six members of the public who help with all stages of the research from developing aspects of the research design through to "disseminating the results" (NIHR, 2016). According to the suggested methodology, the advisory group is a useful way to get insight from experts in the area of the Arabic community. The expert advisory group were engaged not only to provide input and feedback on the research but to help me reach a larger scale of participants in the next stages of data collection; the online survey and the face-to-face interviews.

Outlined below are the members who were approached via an invitation letter, and who responded to express their interest in joining the group: Dr *F*, mental health nurse; Dr *H*, Saudi scientist President of the Saudi student association in Melbourne for the ladies committee; Dr *B*, mental health researcher, and an international student; *E*, consumer representative on the Australian and New Zealand College of Psychiatrists Board Committee on Community and Professional Development Relations. He is part of the Qubtic Church community of Victoria; *A*, Manager of Arabic Welfare service in Victoria for over 8 years, senior social worker; *Sheikh Abo*, Muslim leader and religious advisor (Monash University Chaplaincy); Dr *J*, an RMIT Lecturer and researcher in Arabian societal culture, cross-cultural management, social identity, bicultural identity integration, the dynamic constructivist approach to culture as well as organisational behaviour and international management.

The advisory group sessions were held in RMIT, and the members were invited to share their expertise and give advice on the questionnaire on mental health. The meetings were intended to allow me to gather insight into the main areas of literacy. The group was successful and have given rich information about what I required to include. A copy of the invitation letter per the approval of the ethics committee is attached in Appendix 5.

The advisory group have commented on the design and implementation of the research as well as informing the design of the online survey and in-depth interview schedule. As the meetings unfolded, I asked for verbal consent to record their voices and name, I explained my research and what I am focusing on, and we had three long meetings. All the data gathered and how it informed this research is explored and analysed in Chapters 6 and 7. Community engagement was utilised, the advisory group helped by giving their feedback in informing and drafting the online survey questions as well as the face-to-face questions. And this provided the opportunity to strengthen the questions on the intercultural questions and challenges; whilst also drawing on some of the vignettes from the national mental health literacy survey.

3.4.2 Online surveys

Online surveys in qualitative studies play a major role when considering anonymity in culturally sensitive areas of research such as mental health in non-English-speaking communities. This is explored in the literature review in Chapter 4, which covers mental health and the Arabic-speaking world, health disparities and the level of health literacy in the non-English speaking community. Online surveys are considered culturally appropriate as they provide the privacy and anonymity (Suarez-Balcazar, Balcazar, & Taylor-Ritzler, 2009; Wright, 2005) that other research methods do not offer; for example, focus groups. Considering that mental health is a sensitive area for research, online surveys have allowed me to reach the target audience across a wider geographical range. They have also provided me with a better chance of reaching a larger sample size, as they can be done remotely. As Wright (2005) posts in his research, while people often discuss issues of mental health amongst themselves or their families or close friends; there is still very little evidence of this happening as group discussions outside of these more intimate groups.

It is important for me to remind the reader that this is a mixed methods research ; and that this survey is seeking qualitative information, aiming to explore different views and perspectives from the community, considering online surveys are culturally appropriate as they provide privacy and anonymity (Suarez-Balcazar et al., 2009; Wright, 2005) while other research data collection methods do not offer; for example, focus groups or the sole use of interviews. Considering that mental health is a sensitive area of research in multicultural communities, online surveys will allow me to reach the target audience across a wider geographical range. Some people often discuss issues of mental health amongst themselves or their families or close friends whether in the Arabic-speaking community or even other communities; there is still very little evidence of this culture-sensitive space to allow group discussions on sensitive issues like mental health (Wright, 2005). One advantage that an online survey offers is the anonymity

of virtual communities – and this offers a useful way to connect with people who share specific interests, attitudes, beliefs, and values regarding an issue, problem, or activity. This was my main concern having done a similar minor thesis titled: *Counselling in the Saudi Arabian community: the cultural and institutional barriers* (Abuzinadah, 2012), where it was challenging to be recruiting and gaining the trust of the community; after three months of recruiting I had only 8 participants, and I found it hard to explain the research aims to them, while building rapport and gaining their trust, although I had the legitimacy of confidentiality and ethics clearance, which were stated in the participants consent letter, provided to them in Arabic and English. Having that experience and after working with the community, I believe in “the ability of the Internet to provide access to groups and individuals who would be difficult, if not impossible, to reach through other channels” (Wright, 2005. para. 5). This led me to include the online survey as a recruitment, trust-building and data collection method.

Nevertheless, quantitative research is well-known for using surveys as an instrument to collect data, as it describes the numerical distribution of a variable or variables, such as how many or how much, in a given group (Creswell, 2013). The main concern about quantitative research is that it is the means to measure and gather statistical information and deals mainly in numbers and figures. On the other hand, using surveys as a method or tool in qualitative research has a way of defining and investigating variations in the research group and adding more depth to quantitative numerical statements. The survey that was included in this research does not aim at proving or investigating frequencies, means or other parameters; it merely aims to determine the diversity of opinion on some topic of interest within a given population. This type of survey does not count the number of people with the same characteristic (value of the variable) but it establishes a meaningful view of and helps to give insight into the participants’ own experiences. A typical mode of qualitative surveys is to ask open-ended and multiple-choice questions to a certain number of people or until saturation is reached, but this will not be

“realistic” if grounded theory used aiming to create and develop an exploratory approach to the research per the earlier dissection in this chapter (grounded theory section).

Grounded theory in this research will serve as two different functions in regard to data collection. According to Charmaz’s (2006) approach, on the one hand, it will serve to gather data and generate new concepts and ideas like most types of qualitative research. On the other hand, it will be a unique model for this research that aims to generate explanatory theory that is grounded and “pulled” from the data, due to the gap in studies of intercultural mental health literacy in non-English-speaking communities. One other helpful aspect of grounded theory is the ability to identify multi-source and multi-site data collection and analysis, as Creswell (2013) has noted the relationship between grounded theory and qualitative surveys. Grounded theory has been helpful in generating new concepts and understandings in my research, which are drawn from the community and the information that is gathered along this research journey. This survey helped the community to have an anonymous insight into the type of questions in this research, before inviting them at the end of the online survey to provide their details if they would like to elaborate on their answers or participate in a face-to-face interview.

The survey process started with an invitation being sent to the managers of services and organisations involved with the Arabic-speaking community in Victoria, and the advisory expert group mentioned earlier in Chapter 4. They were also invited to send it on to their members, along with details of the survey link on Qualtrics™, and encourage them to participate. Some of the organisations that were contacted: Monash University Islamic Chaplaincy, RMIT University Islamic Society, the Arabic Social Services, The Multicultural Hub organisation, the Saudi Student Association in Melbourne, the royal embassy of Saudi Arabia and the Ethnic Council of Victoria. I also snowballed the invitation through my personal social media account on Twitter and Facebook, by stating the eligibility criteria and confidentiality in a friendly, professional and culturally sensitive manners, using Arabic term

like “Jazakom Allah Kayerean” جزاك الله خيرا (may God reward you) “kan Allah fe awn alab madam fe awn akheh” كان الله في عون العبد مادافى عون أخيه (God is at your service as long as you assist others by Prophet Mohammad). Such statements have helped to break the ice with many of the followers I have on my accounts. The assistance of the community members and organisations helped to achieve 165 respondents without any exclusions. More information about the participants is provided in Section 5.2.

The survey was completed using Qualtrics and was presented to participants in Arabic and English (please refer to the examples below) , and consisted of a list of 31 questions, which were informed by five significant studies; two Australian and three Arabian. It included both multiple-choice and open-ended questions, meaning it was able to collect quantitative data. The questions were also developed after reviewing the literature and acting on the advice of the advisory group community experts, who gave feedback on and suggestions about the initial questions following the community engagement process. The survey starts with some socio-demographic details of participants, such as age, gender, background, religion and country of birth. The survey was created in both English and Arabic side by side to ensure the participants’ full understanding, with first page stating the confidentiality terms and the eligibility criteria, while the last page had an invitation to participate in a face to face interview by leaving their email/phone, encouraging participants to take part and offering a free thank-you ticket to a workshop about relaxation and de-stressing techniques.

The first study that informed my research and this survey was published as the *Recognition of mental disorders and beliefs about treatment and outcomes: findings from an Australian National Survey of Mental Health Literacy and Stigma*, which was based on the *National Survey of Mental Health Literacy and Stigma* conducted by the Department of Health and Ageing, Canberra (Reavley & Jorm, 2011a). As mentioned in Chapter 2, Jorm is one of the pioneers in mental health research and was the driving force behind the term “mental health

literacy” (Jorm, 2000). The aim of this quantitative study, which was carried out by phone and in which 6019 Australians aged 15 or over participated, was to assess recognition and beliefs about treatment for affective disorders, anxiety disorders and schizophrenia/psychosis. Participants were presented with a case vignette describing either depression, depression with suicidal thoughts, early schizophrenia, chronic schizophrenia, social phobia or post-traumatic stress disorder (PTSD). Questions were asked about what was wrong with the person, the likely helpfulness of a broad range of interventions and the likely outcomes for the person with and without appropriate treatment.

As it was an Australian study, it was prepared and conducted in English, which immediately excluded anyone who was non-English speaking; 77.7 % of the participants were born in English-speaking countries (Australia, New Zealand and the UK) and, when asked about their language, 81.4% indicated they spoke only English. Furthermore, only 1.1% indicated they spoke Arabic besides English. Clearly, there was a gap in the data when it came to assessing the recognition and beliefs about treatment for mental health disorders in non-English speaking communities, including the Arab community, where this plays a major role in mental health literacy.

The questions asked in the national survey were clinically thorough in regards to the signs and symptoms of mental health issues and provided me with a helpful guide in developing a culturally competent, brief survey that would help to bridge the gap in the national survey data caused by language difficulties.

As an example, one of these vignettes was used in my survey (Q15, Appendix 7) with a scenario where an English name was used for an English-speaking audience, changed to an Arabic name “Fatmah”, to help the participants relate to it culturally. The choices were also changed to reflect the cultural responses that may be present which were determined during the discussions

I had with the expert community group and reviewing the relevant literature, in addition to my own experience working as a practitioner with the community.

The second study that informed my survey was developed through the University of Western Sydney (UWS) and the NSW Refugee Health Service, titled “Mental health literacy in a resettled refugee community in New South Wales: Paving the way for mental health education and promotion in vulnerable communities” by S. Slewa-Younan et al. (2014), and Jorm was part of the team. The quantitative data were collected from re-settled Iraqi refugees attending the Adult Migrant English Program (AMEP) at a number of different colleges across the Western Sydney region of Australia. The study was advertised at these colleges through flyers distributed by two bilingual (fluent in both English and Arabic) investigators. The questions were regarding demographic information, a mental health literacy survey and psychometric assessments of psychological functioning. Data were collected from 255 participants using pen-and-paper surveys. The findings of this study suggest “a two-pronged approach to increasing mental health literacy and treatment uptake in an Iraqi refugee population. Firstly, refugees themselves should be targeted with educational material regarding mental health. Secondly, health professionals should be made aware of transcultural issues regarding religion, resettlement time, treatment preferences and knowledge concerning access to mental health care services in this population” (Slewa-Younan et al., 2014, p. 45).

The third study that informed my survey is “Cross-National Comparison of Middle Eastern University Students: Help-Seeking Behaviors, Attitudes Toward Helping Professionals, and Cultural Beliefs About Mental Health Problems regarding this important health issue” Al-Krenawi et al. (2009). This was a cross-national quantitative study, and the data was collected from a survey distributed at Ein -Shams University (Cairo, Egypt), University of Haifa (Haifa, Israel), University of Kuwait (Kuwait City, Kuwait), and Berzeit University (Ramallah, West Bank, Palestine). The data was based on a survey sample of 716 participants, 61% female and

39% male. The findings indicates that the participants from different countries, based on their nationality, gender and level of education, vary in terms of recognition of personal need, beliefs about mental health problems and the use of religious or traditional healing approaches compared to western medicine or “modern approaches to psychiatric therapy” as the study states.

The fourth study to inform my survey by the Department of Family and Community Medicine, Jazan University, Saudi Arabia by (Mahfouz et al., 2016) published as “Mental health literacy among undergraduate students of a Saudi tertiary institution: a cross-sectional study”. This study aimed to investigate mental health literacy and attitudes towards “psychiatric patients” among students of Jazan University, and it was conducted among undergraduate students using a questionnaire. A total of 557 students participated. This quantitative study found the majority of students (90.3%) have intermediate mental health literacy.

Based on these four studies, the literature review and advisory group workshop, I developed my culturally appropriate survey for the Arabic-speaking community in Victoria.

The online questions and ongoing analyses have also assisted in refining the face-to-face interview questions. Different scenarios in the online survey also provided an opportunity for respondents to reflect on what they believe constitutes a mental issue or challenge and elicited their responses to it through a range of options. The following scenario was presented in the online survey:

Mary was staying away from work and family gatherings; she seemed quiet and sad; she is not eating as usual. Her mother is saying that evil eye has infected her, and that is why she is not going out and not talking much. Her mum says she cries a lot. ”

Would you think that Mary is:

3 Suffering from evil eye

4 *Has depression*

5 *Not sure*

How do you think Mary could best be helped?

a. *See her GP*

b. *Seek advice from her community religious Shaik or elders such as grandmother/ante.*

In the above scenario, the name Mary was used for an English-speaking audience, but this was changed to an Arabic name to help the participants relate to it culturally. The choices also were changed to reflect the cultural responses that may be present. These were determined during discussions between the expert community group and the researcher. The rest of the survey contains questions to determine the respondents' knowledge of and views about various people who could help, and whether each category of person was likely to be helpful, harmful, or neither, for the person described. There are also questions pertaining to knowledge of likely prognosis, knowledge of risk factors, and beliefs associated with stigma and discrimination.

The culturally modified example used is presented below:

Q15 Fatmah (your relative), was away from her new job as a manager, community events and family gatherings. She seemed quiet, sad and not eating as usual. Her mother says that "Evil Eye" has infected her after being assigned as a Manager, and that is why she is not going out and not talking much. Her mom says Fatmah cries a lot, has stopped praying, has lost hope in life and wishes she was dead. Fatmah's grandmother had a dream, and she believes that her neighbour Nadia has made "Ammal" – sorcery – wrapped in a small leather case buried in the backyard. Do you think Fatmah:

فاطمة لم يصبك (تتغيب عن وظيفتها كمديرة جديدة ، ولأنك تتغيب عن المناسبات الاجتماعية والتجمعات ...
الغالبية. عندهم رعب ملتبدو هائلة وحزينة ، بتأكل لك علتها بتقول ولت هالان هام حس وينتبعينها كمديرة ، وأن هذا

سبب عدم خروجها أوتحت هذا الفئرا. وتقول ولالتها أنفاطم تتبلكي الفئرا متوقفت عن الص ؟ وفقدت ا؟مافي
ال حياة وتتمنى انتموت تتوتاح .

ج دفاطمة رأت لمطفي منامها ، وتتوقد أن جات هاناية عملتلها "عمل" -سحر-مفوففي لئيسجلدي
صغيرمدفورفي الفيلخل في منمنزلهم. ... هل تتوقد أنفاطمة

☐ *Has been affected by the "Evil Eye" due to her new good job/ تتأثرت وقتهلخون*
لمحسودة في هاصلت لوى وظفة جيدة (جيدة) 1

☐ *Her neighbour (Nadia) has made "Ammal"/"*
(جاتها لئاية)صنعت "عمل" 2

☐ *Is sick & needs to go to a hospital for psychological assessment/ مريضة تحتاج*
لل ذهابلل تشفى لتقيهم هافسري 3

☐ *Needs to pray more as prayers will her get through that (4)*

☐ *Has depression 5 (لبي ه البغائب)*

The above example was used in the actual survey. Please refer to Appendix 7 for a copy of the online survey.

3.4.3 Face-to-face interviews

The face-to-face interviews helped me to get more information from the participants by asking them semi-structured questions that emerged through observation and analysis of the online survey. To be able to recruit participants for the face-to-face interviews, a number of processes were established that took into consideration the cultural sensitivity and the anonymity the online survey provided. As a starting point, the final question in the online survey asked participants if they are interested in a follow-up, face-to-face interview on themes identified in the online survey responses. If so, they were requested to provide their contact details in order

for more information to be provided to them via a link. Having online survey participants involved in the face-to-face interviews was extremely valuable, given their prior knowledge of the questions from the research. They also had valuable feedback about other areas not mentioned in the online survey, which provided me with more in-depth information about community views. Furthermore, an email was sent to the experts advisory group members asking them to help circulate the survey and face-to-face interview invitation through their large network of clients and service partners. I had 20 interviews with 21 people (one father and daughter) The questions for the face-to-face interviews were finalised following analysis of the main themes identified in the online surveys. A list of the questions is presented in Appendix 2.

As mentioned before, I made sure that the participants were aware of the ethical consideration and the sensitivity of the matter by providing a detailed written explanation in English, and Arabic if needed. I also offered to meet the participants in a convenient, safe location according to their needs. The face-to-face interviews were audio-recorded with the appropriate permission and transcribed with analysis using NVIVO.

3.5 Sampling procedure and inclusion criteria

The research design employed mixed method, included both quantitative and qualitative methods and was specifically targeted at Arabic-speaking adults. This was an exploratory study using different techniques, research tools and methods. Participants numbered 165 for the online survey, 20 for the interviews and eight Advisory experts who made a significant contribution toward shaping this research. More information regarding the composition of the participant group appears in Appendix 6.

The participant numbers were a good reflection of the makeup of the Arabic-speaking community in Victoria (5.5%). In real terms, that's a total of 69575 Arabic-speaking people out of the total number of people who speak a language other than English at home, which was

shown to be 23% of the Victorian population. (ABS, 2016; ABS Census, 2001). Due to cultural reasons; for example, female segregation, and the fact that the researcher—myself—is a female, it was more likely that females rather than males would choose to participate in this type of research. As the data collection process unfolded, I interviewed six men, and the survey responses indicated that 30% of these participants were male. The diversity of the ethnic group backgrounds intended for this research have enriched the study sample and provided a good overview of the different ethnic groups that an “Arabic person” could be identified with. The inclusion criteria specify people who identify themselves to be of Arabic heritage, who live in the state of Victoria, and who can read, write and speak in Arabic, and above the age of 18.

The participants who completed the online survey were then invited to a follow-up, face-to-face interview. The face-to-face interviews were audio-recorded with the appropriate permission and transcribed with analysis using NVIVO. Further information regarding the participants is presented in Chapter 5.

3.6 Data Analysis methodology

The use of grounded theory has helped to involve the participants -as a part of the Arabic-speaking community -through a culturally sensitive approach; that was feasible and enabled me as a researcher to collect the data and analyse it simultaneously.

Both Chapter 5 and Chapter 6 will discuss the analysis and the findings. The chosen approach for analysis is narrative analysis; this approach helped in engaging, sharing and understanding the research participant through similar narratives, knowledge and experiences around mental health. I had the privilege of listening to so many stories from my community through this research, an approach to “conducting narrative analysis that accounts for the ways in which people position themselves through telling stories’ (Stephens & Breheny, 2013, para. 1). These stories were translated into English, and I feel it is a great responsibility and an honour to share them as my community wanted them to be heard. And as this research “does not fit neatly

within the boundaries of any single scholarly field” (Riessman, 1993, p. 1), narrative analysis helps me better locate the stories I have heard, felt and shared with my community- Refer to Appendix 4 Glossary of Arabic terms translation and meanings.

The process of moving from data collation was an ongoing “tango dance”, between becoming an insider within the community, the moving to an outsider (Ellis et al., 2010), on my own desk in RMIT trying to paste together my notes, memos, observation and weaving that all into a research chapters, between memories from far past to the one that resonated with me in the interviews. I found it difficult to move from data collection to analysing and reporting. There was a ‘line in the sand’ where I stopped collecting more data and reached saturation, after my 20th Interview. And between the interviews of my participants, I was transcribing the interviews and translating it from Arabic to English, I did feel that so much will be lost in translation and that was one important aspect in creating the themes that I will discuss later, but the themes emerged iteratively. At the same time, I was writing up countless field notes and reflections on participant expressions and stories. I started to use NVIVO software but ultimately found that I was able to extract the main themes through a process of word frequency search; identifying key themes that were linked to some main expressions and concepts from the advisory experts' group, for instance, “Evil eye”, and collating them accordingly. I collected a large amount of material that was rich and in-depth. I feel that I hold this traditional, yet professional respect for participants who are elders; however, there was a range of similarities in perceptions and some deeply shared knowledge that the community held regardless of their age.

Due to time limitations, it was necessary to employ NVIVO, which was useful in reminding me of my positionality and subjectivity. I coded the advisory group meeting, my memos and notes, interviews, surveys’ open-ended questions and interviews’ transcripts into approximately 25 different categories (nodes/codes). It took me a while to begin to see overlapping themes and was able to collapse these into 3 main emerging themes that included

5 to 6 subcategories. Once I had extracted key themes, I began collating all of the other memos, hand-written notes in Arabic and all the maps of messy hand drawing, into clear categories. It was eloquent to see the themes linked to the research questions in such unexpected ways this was a time consuming yet very rewarding process between transcribing, translating, connecting to the data as a practitioner, insider-outsider and observing bias along this journey. However, similar stories kept emerging and reinforcing the importance of the data collection methods I had identified, resulting in the themes outlined in the two final chapters.

Finally, when reporting data in the findings' chapters, in order to ethically maintain confidentiality, I created pseudonyms for all research participants. I explained clearly and repeatedly throughout this research, personally, on the phone and via emails that they would not be referred to by their own names, and most of the participants were pleased about this persistence which is a necessity when working with the Arabic-speaking community, which encouraged few to refer their friends to the study.

IX) Literature Review

Chapter 4: Mental health literacy

4.1 Introduction

This chapter is a review of the current literature on mental health literacy. It is subdivided into several sections, starting with looking at different studies on migration and transnationalism and how they play an important role in regard to health disparities and health literacy. This led to an examination of health disparities; and how people from CALD communities have different health characteristics compared to Western- or non-CALD background- communities. From that, stems a review of mental health disparities and literacy in CALD communities, where contributing factors such as culture and religion are analysed. Finally, the question of how that influences the way the Arabic-speaking community perceives and understands mental health is addressed.

A review of the research literature related to mental health literacy is conducted in this chapter. Multiple databases were searched for the following terms and combination of terms: health literacy, mental health literacy, promotion and evaluation, migration, transcultural mental illness, depression and stigma, prevention, treatment, public education and campaigns, perceptions, cultural attitudes, attitude change, religion, and mental health. Databases included MEDLINE and CINAHL (Medicine), Social Sciences Abstracts, PsycINFO, Sociological Abstracts and Social Services Abstracts (Social Work).

Other cited references are from relevant journal articles included in the reference list and obtained through database or web searches. The literature relating directly to mental health literacy mostly emanates from Australia and Europe, where researchers have studied public knowledge and beliefs about mental illness and mental health. Most of the other literature reviewed was related to stigma, public attitudes and perceptions, and public education about mental illness and mental health. Most of the research was focused on depression and

schizophrenia, with a smaller number of research articles relating to other mental disorders such as substance abuse or anxiety disorders.

4.2 Culture as a main factor impacting mental health literacy

This literature review highlights the range of theories and approaches that inform this area of research. Relevant literature is drawn from mental literacy publications, with particular attention paid to cultural issues related to mental health and Arabic communities. Many issues in the Arabic communities are kept private and dealt with in families (Hamid & Furnham, 2012). Furthermore, many Arabs, particularly in western countries like Australia, rely on family for emotional support, and the family is seen as being of central importance (Kayrouz et al., 2014). Among Arabs generally, it is culturally accepted as the norm that disclosing family issues or any psychological problems is not appropriate, as it brings shame to the family as a whole (Haj-Yahia, 1995). Additionally, many people in Arabic societies prefer to deal with their emotional problems and life obstacles within their family, or they might seek advice from trusted extended family members or close friends (Al-Krenawi & Graham, 2000a). The “centrality and significance” of the family may enrich an Arabic person’s life by offering them an extended network of emotional support and guidance when facing any social issues (McGoldrick, Giordano, & Garcia-Preto, 2005). On the other hand, there is an expectation for religious Arabs—which are the majority—to not only live to please their God and themselves but to please their family as well, which is another factor that may cause them stress (Haj-Yahia, 1995). Nevertheless, although some of the reviewed literature may be dated, it is argued that culture is a motion of change along the years (Awaad, 2003). It is also noted that social factors such as migration will have a major impact on an individual’s life, and it will change their cultural and social structure (Al-Krenawi, 2014). Further investigation in the literature is in progress, as these older propositions may require interrogation.

According to scholars like Vogel (2000) and Voloder & Kirpitchenko, (2016) social norms have not been the main direct influential avoidance factor, when it comes to seeking help from available social services, although attitudes transmitted by family members and by friends play an influential role in how an individual defines and acts upon feeling distressed. Some people tend to see social and welfare services as a last resort; something which might be considered only after they have unsuccessfully attempted to handle things on their own, or if the people close to them have somehow failed to help them (Vogel, 2000). Some Arabs also seek informal help from religious leaders on a variety of issues (Haj-Yahia, 1995), including family disputes, financial matters, marriage/relationships and emotional distress. Religious leaders report that their congregants come to them for a full range of emotional problems, marital and family problems, and psychological and social concerns. Haj-Yahia (1995) argues that among Arabs, there is a tendency to seek religious and spiritual interventions due to fear of stigma or lack of awareness around mental health issues. Moreover, they would integrate back into the community, which is an essential part of supporting someone with social problems or during traumatic times (Savaya, 1998). However, these key studies do not highlight the new generation of Arab who might have different views concerning seeking help. Examining these views and attitudes was a core factor in my proposed research.

A number of important factors will be addressed in this research such as the influence of culture, the presence of stigma and the fear of shame when seeking help or assistance from social and welfare services due to social stigma, which is “structural in society and can create barriers for persons with a mental or behavioural disorder. Structural means that stigma is a belief held by a large faction of society in which persons with the stigmatised condition are less equal or are part of an inferior group” (Ahmedani, 2011, p. 6). In other words, the fear that others will judge us negatively if we seek help for a mental health problem. Therefore, the presence of stigma will have a negative impact on people’s attitude toward seeking professional

help (Loya, Reddy, & Hinshaw, 2010). Another important factor to be addressed in this research is how the lack of awareness of available services may lead people who are experiencing social and/or emotional issues to avoid or ignore the problem. This ignorance about help options will have a major impact on their life and will eventually affect their families. In some cultures; for example, the Saudi culture, it is believed that the best way to deal with problems is to ignore them by avoiding thinking about them or “dwelling” on them (Deane & Chamberlain, 1994). Al-Darmaki, Thomas, and Yaaqeib (2016) argues that many of the younger Arab generations seem to have personal, career, educational, and social needs, which would benefit from social services’ assistance. Interestingly, younger Arab generations take it a step further and believe that social and welfare services may not only benefit people, but it is also their right (Al-Darmaki, et al. 2016).

Although there is a general lack of English and Arabic literature in the field of mental health social and welfare service delivery to Arabic communities in Australia, some literature in the field of multicultural studies has been useful. The research literature review explored – and translated the Arabic literature as needed-; and other related literature about social and welfare service delivery to Arabic communities in countries like the United Kingdom, the United States of America and Canada.

4.3 How do we now understand migration and transnationalism?

People migrate for many reasons and the “Push and Pull theory” (Donato and Massey, 2016) has been explored by many studies and noted by many scholars in an attempt to understand these reasons (Parkins, 2010), which has helped our understanding of the experiences encountered by migrants, refugees, asylum seekers and international students.

People may be “pushed” out of their countries by dissatisfaction with their lifestyles, or they might be escaping from tough conditions such as war, economic instability, racism and more. They might be escaping family violence, human rights breaches and/or natural disasters. On

the other hand, people will be “pulled” into another country by the promise of freedom, justice, better jobs and/or safer political conditions for them and their families. Moreover, they might be pursuing a better education to obtain a better career in their home country or their new country (Donato and Massey, 2016). In order to understand the impact of migrating to Australia, we need to understand how and why people do it.

For the purpose of this research, the groups identified previously will be referred to as “People Who Migrated” as the general act of migrating is what is similar between them. They all moved from their home countries for different reasons, different paths and different plans for the future. However, exploring mental health literacy among different groups of people who have migrated to Australia from an Arabic diaspora/country and are still living in Australia have helped this research to establish an understanding of the issues on a larger scale, which is a gap in current research.

Many studies have explored the impact of migrating or moving from one country to another, and some have highlighted the effects on individuals, such as residing in one country but still having relationship ties and feelings of belonging in another. It has been identified by anthropologists that many people who migrate experience living their lives caught between two borders, and in some cases three, as Baldassar (2007) explains. They maintain their relationships and ties to their “home”, regardless of the distance and how well they have settled and adapted to the new country. A “contemporary” family (Baldassar, 2007) has been revealed through research, which has shown that it is very common to have family members living a great distance apart, and still remain as a family. Many contemporary families will choose or be pushed to live apart for any number of reasons, which may have great emotional and social effects on its members.

Falicov (2005, p. 299) makes an interesting comment about the impact of transnationalism, when he states, “If home is where the heart is, and one’s heart is with one’s family, language, and country, what happens when your family, language, and culture occupy two different worlds?” It would seem, then, that many people who migrate are divided emotionally between two countries. Many people maintain their financial and emotional ties with their close or extended family and friends using social media and technologies such as Skype and international funds transfers. With such connections, they can be involved and aware of the day-to-day life, political issues and even market price rises in their home country.

Nevertheless, although people who migrate might still maintain connections with their traditions and home culture, they, after settling, having kids, buying properties, building strong relationships and finding a new community, can find themselves calling their new land “home”. As was quoted by Cox, L. G., & Simpson, A. (2015) home is where the heart resides. Due to such connections in life and relationships, transnationalism could be perceived as living two lives with two hearts. According to Stone, Gomez, Hotzoglou, and Lipnitsky (2005), there is a great impact on transnational children who are born in a different culture to the original culture of their parents. It brings some insight into how a parent would practise that role and duty without their extended family role. An example would be a migrant from the Middle East, where the role of the grandparents or older family members is essential in helping to teach the children about discipline such as “respecting elders”, which is displayed by not calling them by their first name. However, in Australia, it is the cultural norm for people to be on a first-name basis, according to the nature of the relationship. Such gaps between the way the parents were raised and how they carry out their parenting role may have an influence on their children. The parents may feel transnational, whereas the children who were born in the new “home” might not understand their parents’ culture, and simply have the “one culture” and the “one home”.

Many transnational families manage to maintain a sense of unity and a feeling of “togetherness”, regardless of the physical distance between them, and they create a collective “family hood”, even across national borders (Bryceson & Vuorela, 2002, p. 3). The concept of emotional transnationalism underlines this aspect of transnational connectivity. Emotional transnationalism refers to transnational connections involving feelings and emotions (Falicov, C. J. 2005). Furthermore, due to significant changes in the social structure in many families, living under the same roof may not be an option, which means they have to make an extra effort to sustain being a family by long-distance. However, not all transnational migrants are able to maintain emotional and financial support for their family from afar, and the awareness of their inability to do so often leads to feelings of sadness and guilt. As a result, some people will find this hard to maintain, knowing that their family – at a great distance – will need support financially and emotionally in which they cannot provide in some cases. Indeed, the feelings of disappointment, sadness and guilt, might make it even harder (Falicov, C. J. 2005). As for international students, scholars like (Al-Darmaki, 2003; Voloder, L., & Kirpitchenko, L. 2016) have identified the challenges faced by them in regards to emotional and psychological difficulties which will be highlight in the next section.

4.4 Migration and transnationalism theory

According to Gil-González et al. (2015), “The act of migration itself is not a homogenous process; different individuals migrate for different reasons and also respond in very different ways”. Migration may have a significant impact on peoples’ lives, and it could be felt across several generations (Benson & O’ Reilly, 2009). The term “Migrant” has been used in many references to reflect some of the commonality in the process and in belonging to groups, in spite of the “heterogeneity” (Perruchoud & Redpath-Cross, 2011). Types of migration are different, and the needs behind it vary, although the act of “migrating” in this context means leaving and/or moving to another country. Migrants, refugees, asylum seekers, international

students and displaced people are considered as different groups within the Australian migration system; in their needs, in their goals and in their transition.

The impact of migration following wars and political turmoil, plus the resulting displacement, brings additional factors into play, especially for refugees and asylum-seekers. Some theories suggest that people migrate for the sole reason of achieving a better economic state—“push and pull”, where other research argues that this is not the case with many people who migrate, which highlights the difference between a migrant and migrating as an act (O’Reilly, 2012).

It was noted by Williams and Mohammed (2009) that discrimination and racism in society contribute to the breach of the right to health and health care in migrant groups and ethnic minorities. These groups might experience social exclusion due to potential discrimination, which could be experienced collectively rather than individually. Their disadvantaged situation could lead to a lower quality of living, fewer health benefits, and emotional and mental health issues (Agudelo -Suárez et al. 2009). They also may be affected by the socio-economic structure of the new country, which plays a major role in determining their opportunities to find better jobs, education and or/business opportunities. They are affected by forces that have some impact on the economic and social structure (Abraido-Lanza, Dohrenwend, Ng-Mak & Turner, 1999), which may cause diminished socio-economic opportunities; this influence can result in poorer health, a lower quality of life and limited access to proper services (Gil-González et al., 2015).

It has been argued that poor health is “disproportionately” experienced by those who migrate to a society that has disadvantaged socio-economic conditions (Abraido-Lanza, Dohrenwend, Ng-Mak & Turner, 1999). Nevertheless, other research suggests that newly settled migrants in the host country show better health indicators than people in their countries of origin (Newbold, 2005).

4.5 Migrations and transnationalism impact on health and wellbeing

Many people who migrate will have different perceptions and beliefs about health and how “healthy” a person should be or feel. It is stated by international human rights laws that all human beings should receive equal health service provision regardless of their race, ethnicity, nationality, religion, income and education level. “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control” (UN, 2017, Article 25.1). In fact, looking at the existing systems and arrangements in Victoria, and from my experience as a practitioner working with international students, migrants and refugees and different sittings, they may have limited access to many services. Settlement arrangements will also be an influencing factor on their general health and wellbeing. When considering Victorian settlement arrangements, citizens and permanent residents are able to access Centrelink and Medicare entitlements, whereas humanitarian visa holders and international students may not (Han & Pong, 2015). This is likely to have a major impact on the migrant community in Victoria.

Migrants and refugees receive medical benefits toward psychological intervention and support such as psychologists and counsellors only if they hold a Medicare card. As a matter of fact, they are entitled to access free or subsidised services in most cases, whereas it is different for international students. International students are usually entitled to benefits and cover by OSHC (Overseas Health Cover) that includes hospital, emergencies and general practitioner services. These policies consider counsellors, psychologists and social workers as “extras”, meaning the students have to pay the full fee themselves. The average cost to access such services for an international student is \$143.70 per session, according to the Medicare fees table (AGDH, 2016). Many international students will only be left with the option of seeking emotional

support from the counselling service provided through the university, which is covered by a compulsory annual fee (services and amenities fees). Whether they take this option depends on a number of factors. Migration does have a great impact on peoples' wellbeing; the fact that they are connected to different physical places does affect their life, thinking and feelings. Parkins (2010) confirms that it is migrants' and others' connection to several places and countries that is the heart and the essence of being a migrant, and adds, "Leading transnational, multi-sited lives means that exchanges and interactions across borders are a regular and sustained part of migrants' realities and activities" (p20). However, this idea of being connected to different places will have an influence on people's way of thinking and behaving; it will affect their beliefs, feelings, perceptions political view and status as well as their financial status and contribution to both lands or places (Falicov, 2005). The next section will cover a review of the literature about health disparities, and how migration and living between countries might be emotionally challenging to people and affect their whole life.

4.6 Health disparities and literacy

There are proven health disparities between populations, based on culture and language, with health disparities defined as a "marked difference or inequality between two or more population groups defined on the basis of race, ethnicity, gender, educational level, or some other criteria" (Pearcy & Keppel, 2002, p. 273-280). It is important to highlight the fact that health disparities are crucial to understanding health literacy or mental health literacy.

Furthermore, it is a well-established fact that such disparities are at least partially mediated by the population's understanding of the health issues themselves (Han & Pong, 2015) in relation to the availability of health responses, and in their cultural values and reactions to such health issues. It has been found that the values different cultures hold in relation to mental health, can be particularly difficult for both providers and users of health services (Coffey et al., 2010). Kreps and Sparks (2008) have argued that communities from diverse cultural backgrounds are

the “most vulnerable health care consumer populations, who are at greatest risk of suffering significantly higher levels of morbidity and mortality than other segments of the population” (p. 20).

Functional health literacy is defined as “the ability to read, understand, and act on health information” (Andrus & Roth, 2002, p. 1). Poor health literacy may lead to poor understanding of health conditions and their presence in general (Zarcadoolas, Pleasant, & Greer, 2005). Furthermore, Zarcadoolas et al. (2005) explored health literacy and its complexity and stated that “the relationship between the complexity of health material and the literacy levels of individuals is an important but not sufficient understanding of health literacy” (p. 197). Part of health literacy is mental health literacy, which will be explored in-depth in this research.

Health literacy, disparities and mental health literacy among the Arabic-speaking community are observed and argued by many scholars (Al-Habeeb, A & Qureshi, 2010; Al-Krenawi, 2005; Al-Krenawi & Graham, 2000a; Kenny, Mansouri, & Spratt, 2005; Youssef & Deane, 2006). The Arabic language will play a major role in identifying and exploring mental health literacy, as language may create a “mountable barrier” to service access and understanding for mental health issues and their treatment (WHO, 2001, p. 14-15).

This review of the Arabic literature will assist in identifying where the gaps in and barriers to mental health literacy occur for Arabic speakers and will give an overview of the perceptions, ideas, beliefs and perspectives of the Arabic-speaking community in general.

4.7 Mental health literacy

The term Mental Health Literacy was introduced by Anthony Jorm, a central proponent for mental health literacy. Jorm also leads the Population Mental Health Group within the Centre for Mental Health at the Melbourne School of Population & Global Health. His work and research focus on building the community’s capacity for prevention and early intervention with

mental disorders. He defines mental health literacy as “the knowledge and beliefs about mental disorders, which aid their recognition, treatment or prevention” (Jorm, 2000). Previous studies on mental literacy have explored the way people perceive mental health issues or illness, and how the way it is described or presented have an influence on their beliefs around mental health issues (Furnham & Hamid, 2014). A large volume of studies around mental health literacy has been done in western countries. Australia is one of the leading countries, according to the number of published papers and research done by Jorm and his group in the last 20 years (Jorm et al., 1997). These studies have made a major contribution to improving the public awareness around mental health issues and have helped to establish well-designed programs and tools to enhance the public awareness around mental health issues, focusing on knowledge and skill development (Kitchener & Jorm, 2002).

Jorm (2012) has been researching mental health literacy for many years. In his article “Empowering the community to take action”, he reports on a study conducted in 2006-2007 which explored community awareness regarding the helpfulness of professional services provided by psychologists, counsellors and other mental health care service providers. The groups included in many of these studies were small and limited, and the studies were conducted in Australian English, which excluded non-English speaking communities. This lack of research about the mental health literacy of people whose main language is not English, such as Arabic-speaking communities, is particularly concerning considering the growing minority group’s status due to the increased numbers of Arabic-heritage-identified people coming to Australia in recent years to escape the intensified war and conflict during the past five years in the Middle East. Furthermore, according to the new immigration and humanitarian aid regulations, many people from Arabic countries are settling in Australia, and many of them have been through horrific experiences before arriving (Coffey et al., 2010). Many of these newly arriving migrants, refugees and asylum-seekers may be experiencing post-traumatic

stress disorder and other mental health issues (Kreps & Sparks, 2008). Literacy about mental health issues plays a major role in informing these affected groups about their wellbeing and also impacts their attitudes towards service access (Jamil et al., 2002). The mental health services in Australia are well-developed compared to other countries (Al-Krenawi, 2005), and are potentially useful for many newly arriving people; for example, people from Syria or Yemen, if they are tailored appropriately to their needs. However, the mental health system and service providers in Australia are still in progress to create a fully compatible service for culturally and linguistically diverse communities (Youssef & Deane, 2006).

The gap in the literature related to the mental health literacy in non-English speaking communities has been identified by a number of studies such as Ganasen et al., (2008) who conducted a thorough review of published resources around mental health literacy in non-western communities between the years 1990 to 2006. Moreover, a recent review of the literature on mental health literacy in non-western countries by (Furnham & Hamid, 2014) supports these earlier claims made by Ganesen et al., (2008). Hence, the findings of these studies have identified some of the limitations to finding relevant literature, such as terminology—some authors use the term “Mental Health Literacy” and others will use “Psychiatric Literacy”. In other studies, scholars may refer to “Mental Health” as “Mental Illness” or “Illness of the Mind” (Martin, 2009), which is notable in Arabic literature (Al-Krenawi, 1999). The review of Arabic language terminology through the data analysis will identify these inconsistencies in terminology. Other limitations were also identified, such as the sensitivity of the issues in non-western communities, cultural perceptions, and religion. According to Furnham and Hamid (2014), the “majority of the studies around mental health literacy were done in western countries”, and a significant research contributor to mental health literacy is Jorm and his associates in Australia. Many of the studies are based on large representative populations in Australia, who undergo a structured survey, often by telephone.

Jorm et al. (1997) have been particularly interested in depression and schizophrenia and the perceived pathways of treatment. Other research has been conducted by Gawad and Wincelhaus (2012) and Furnham et al., (2011), mainly looking at personality disorders and more recently conduct disorders. Mental health literacy is the core of this research, however, in the final chapters of the research (5&6) I have investigated the following: What is mental health literacy in the western and non-western communities and how do people define it? How is it measured? Will it be accurate in accordance with current research and theories?

4.8 Contributing factors to mental health literacy

The Arabic-speaking community is not aware of many mental health issues or is ignorant about them due to many social factors (Youssef & Deane, 2006). This will hinder their understanding of mental health issues, accessing of welfare services and trust of professionals. In addition, the availability and accessibility of services in Victoria will be considered during this research, as one of the important contributing factors.

As a result of many religious and cultural factors, mental health issues are commonly avoided when it comes to community awareness and care (Zahid & Ohaeri, 2013). Furthermore, according to Al-Krenawi and Graham (2000a), many Arabic-speaking individuals hold a belief that a mentally ill person is possessed by demons or evil spirits. Therefore, mental health issues are highly shameful to have and be affected by. Moreover, shame and stigma are the most common factors that contribute to mental health literacy, as highlighted by Jorm (2012).

There are many factors contributing to mental health literacy. Awaad (2003) identifies themes that contribute to mental health awareness and claims that “religious and traditional influences determine mental health beliefs, attitudes and behaviour”. The three main themes that emerge in the literature (Awaad, 2003; Gawad & Rahman, 1989) are “the presentation of emotional distress, the beliefs of causality, and health-seeking behaviour” (p. 411). Hence, emotional distress can be presented in many Arabic communities as violence, insomnia and/or anger

according to Awaad, (2003). He also highlights that there is a close link between beliefs about the causes of mental health problems and spiritual teaching and interpretations, with many individuals seeking religious advice to overcome depression (Awaad, 2003, p. 411). The topic of health-seeking behaviour is connected in the literature to themes such as stigma, culture, traditions, customs, family, trauma, religious beliefs, education and socioeconomic status. In many studies, shame and stigma appear to be “the overwhelming hindrance to accessing services, due to the strong cultural prohibitions on exposing any personal or family matters to outsiders.” (Yousef, J.& Frank, D., 2006, p. 43).

According to the literature search conducted so far, it is clear that more work needs to be done in better understanding the Arabic-speaking community residing in Victoria to highlight and explore their beliefs about mental health issues. A report that was prepared for the Victorian Department of Human Services by the Victorian Foundation for Survivors of Torture highlights some of the issues and beliefs concerning mental health in the Arabic-speaking community but identifies the group studied as consisting of only refugees and asylum seekers (VFST, 2004). In Victoria, however, there are many people who identify as Arab, including skilled migrants, refugees, asylum seekers, international students and other humanitarian visa holders (Kenny, Mansouri & Spratt, 2005). The current research, therefore, included a cross-section of Arab-speaking participants in order to fill the gap in the literature as, according to Yousef and Frank (2006), the underutilisation of mental health services by different ethnicities, cultures or religions will differ, and in the Arabic community is highly ignored. In the United States, for example, several studies with minorities such as African Americans, Latinos, Asian Americans, and American Indians have been investigating mental health literacy and the underutilisation of services; however, little research looks at the Arab and/or Muslim minority in the United States and Australia (Hamid & Furnham, 2012; Han & Pong, 2015; Jamil et al., 2002).

With the war in the Middle East, the numbers of Arabic-speaking people in different communities and cultures have grown. The number has also grown in conservative societies where there are certain expectations placed upon individuals, especially concerning the way life is perceived, the way they should be thinking and the way they ought to feel. In some cases, it is necessary to act in a certain way to seek approval of the group or the community. There is a certain way you are expected to “be” (Al-Krenawi, 2005). That means putting people who experience mental health issues or illness into a category or a “box” with other misfits or people who cannot “be”. As a result, in many cases, the families of these people intentionally avoid talking about the issues or seeking help. They avoid being seen with that family member (Al-Habeeb, TA, 2002) as they also might be labelled, shamed, excluded from community and religious gatherings. The lack of support might also force people to “choose” to be ignorant about an existing mental health issue. Yousef, J.& Frank, D.(2006) states “denial of the possibility of mental illness in the community” (p.44) is a hindrance facing the Arabic-speaking community, which plays a role in acknowledging mental health issues which may affect their help-seeking attitudes.

Religious beliefs play an important role in the Arabic culture. In some cases, having a family member affected by an issue may cause the family to adopt a well-known Arabic concept known as Destiny and fate (قضاء وقدر). It is an Arabic word that means to depend on God or to trust in the destiny of a situation or problem that has arisen through God’s higher power.

In simple terms, it means placing complete and utter trust in God or a higher power. In Islam, it means trusting that God or Allah is a guardian, or that he is watching over people, and nothing can happen without his orders. This concept is based on the strong belief that no-one can harm an individual nor be of benefit to them without it being the will of God or Allah. It is written in the Holy Quran: “Truly no one despairs of Allah’s Soothing Mercy except those who have no faith” (Quran, 12: 87) and, “Remember Me, and I shall remember you; be grateful to Me,

and deny Me not” (Quran 2:152), and “When you have taken a decision, put your trust in Allah” (Quran 3: 159).

There is strong religious belief, especially amongst the Arab-speaking community; that a “true Muslim” must always trust in God in a situation of stress (Al-Krenawi & Graham, 2000b), which will give them the feeling that a higher power, Allah, is with them and no-one can harm them, unless it is the will of Allah. This is certainly a major relief, which provides some people with the feeling of safety and tranquillity (Hassan, Mir, & Hassan, 2016; Thomas & Ashraf, 2011). Unfortunately, depending on their awareness and level of education, some people may choose to ignore the facts about their emotional condition or the severity of their mental illness, preferring to rely on fate or destiny – the will of Allah, which I will talk about in the analysis and finding in Chapter 6. They also may not be fully informed about the medications they have been prescribed and may believe that this is an act of “jinn” evil or sorcery (Bailey, Harries, Latif & Saeed, 2010; Thomas & Ashraf, 2011), which will also be explored in Chapter 6.

4.9 Conclusion

Undoubtedly, there have been many studies done on “help-seeking attitude” in non-western communities and countries (Al-Krenawi, 2005; Al-Krenawi et al., 2009; Coffey et al., 2010). Hamid and Furnham (2012) have noted that many members of the Arabic-speaking communities residing in the UK are afraid of the attached stigma and other issues that will affect their help-seeking attitudes (Zahid & Ohaeri). Nevertheless, there have not been many studies researching the help-seeking attitudes of Arabic-speaking communities in Victoria.

While mental health literacy, and service utilisation and access is a significant problem, studies have shown that intervention and professional help work with symptom management (Al-Krenawi, 2002). However, underutilisation of mental health services is a real challenge, as many people from CALD communities who may benefit from these services do not take them up; for example, Medicare, (Coffey et al., 2010). Hence, there is still some gaps in the literature.

Analysis and Findings

Chapter 5: Mental health literacy: concepts, beliefs, perspectives and attitudes

5.1 Introduction

In this chapter, an exploration of the concepts, beliefs, perspectives and attitudes related to mental health that research participants have shared and how their responses resonated with the literature and the researcher's autoethnographically recorded experiences. First, the research participants and data summary are presented. Then the analysis will take place through the eyes of the community members who take part in the research community, following in accordance with the findings from data collection. This exploration will pave the path to understanding- "why do they hold such beliefs and values?" that is presented in the next chapter. It also provides a basis for understanding the impact of these beliefs, values and attitudes on mental health literacy. In this chapter, an overview of the participants is provided along with the online survey questions. Then I will discuss the participants' views on mental health and how is it influenced culturally and religiously. I then reflect on this by examining the "how" of the current views participants hold about mental health, while the next chapter will offer a better understanding of the "why". Consequently, this will provide a nuanced answer to how to raise awareness about mental health, using the voice of the community in the final chapter. This chapter paves the way for the examination of non-Western ways and understandings of mental health, with a focus on Arabic Islamic interpretations and cultural views.

5.2 The participants and the data

The research participants' information is presented to give the reader a better understanding of who they are. The online survey involved 165 participants, who answered the questions appearing in Appendix 6.

After the participants indicated that they had read the eligibility criteria and given their consent, the first question asked if they consider themselves to be of Arab-speaking background; 97.44% answered yes. When asked if they understood Arabic and English, 90.38% of the participants responded that they understood both, 8.33% understood only Arabic, and 1.28% fell in the ‘others’ category.

In regard to age groups, 38.46% of the total participants fell in the ‘18-30’ category, 51.92% fell in the ‘31-40’ category, 5.77% were in the ‘41-50’ category, 3.21% of them fell in the ‘51-60’ category, and 0.64% of them fell in the ‘60+’ category.

When it came to religion, 94.27% of the of participants stated that they were Muslim, 1.91% practised Christianity, 1.27% practised Judaism, 0.64% ticked no religion, and 1.91% of them fell in the “other” categories.

When they were asked about gender, 68.15% of the participants were female, 29.30% of them were male, 1.91% of them fell into the ‘other’ category, while 0.64% preferred not to answer.

When it came to “Osoul^{a→}”, most participants’ families were from Saudi Arabia (85.26%), 1.28% of them were from Bahrain, 1.92% were from Egypt, 1.28% were from Iraq, 2.56% came from Kuwait. 1.28% of their families originated from Palestine, 0.64% came from Syria, 0.64% were from the United Arab Emirates, 2.56% were from Yemen and 2.56% ticked “other”, then stated Libya or Australia.

^a → Osoul الأسول: family ancestry, heritage or/and origin.

Most of the participants, 90.38%, were born in their country of origin, 2.56% were not, and 7.05% of them indicated they were born elsewhere.

Participants were asked whether they had attended any training or educational sessions around mental health or wellbeing 36.31% of them answered 'Yes' and 63.69% answered 'No'. Of those who stated to have gone through the training, 29.17% did training on Mental Health First Aid, 27.08% on Psychological First Aid, 43.75% got training on other mental health courses.

For 88.57% of the participants, the term 'Mental Health' meant psychological wellbeing, for 6.43% of them it meant having a sound mind; not being mentally ill and for 5.00% of them it had other meanings like "being mentally ill for sure" or even "both of the first two mentioned meanings". Out of the participants, 15.00% answered that psychological health was more important, 3.57% chose physical health, while 81.43% of them chose both to be important.

With the vignette in Q15 (Appendix 6), 5.00% feel that Fatmah had been affected by the "Evil eye" due to her new good job, which is why she is less interactive in gatherings and feels like dying. 1.67% of them feels that Fatmah's neighbour (Nadia) has made "Ammal"⁵ and buried in the backyard. 35.56% of the participants feel that Fatmah is sick and needs to go to a hospital for psychological assessment. 20.00% of them feel that she needs to pray more as prayers will get her through that while 26.67% of the participants say that she has depression. Some of the participants, 11.11%, were not sure what's the cause of what she is going through.

To assist Fatmah, 10.87% of the participants think that a Sheikh should read verses from the Qur'an, such as Surat Al Falaq, 2.90% of them feel that she should visit a general practitioner and 84.06% of them feel that she should see a psychiatrist or psychologist for help. Again,

⁵ Ammal : عَمَلٌ a slang Arabic (Saudi Arabia-Egypt-Jordan) word that describes an evil charm, black magic/sorcery item that is similar to a Voodoo doll but differ in content and intentions, its content usually is one or more of some items that could be all or one of these grouped in a cloth or leather pocket like (Dominic phrases/ incoherent writings on paper, human or animals hair/blood / nails/urine or fesses, stones, leaves, weed or other items), the Intentions traditionally could be all or one of these (marriage breakup, loss of money/health, sever sickness., loss of intimate marital connection)

2.17% of the total participants think that she should dig around in the backyard to find the sorcery “Ammal” and wash it with holy water, following her grandmother’s advice.

When they were asked about causes of mental illness, 7.12% said it is biological, 6.62% think it is hereditary, 17.22% said it is brought about by psychosocial causes, and 11.09% said it is caused by stressful life events. Having a traumatic childhood was suggested by 15.23%, 2.65% think it is brought about by religious causes, while 9.11% feel it is brought about by spiritual poverty. A small percentage, 0.83%, feel that it is due to not accepting religious leaders’ advice and 1.49% feel that it is God’s will. Another 1.49% feel it is caused by failure to adhere to the tenets of God as revealed in the holy books. Of the total participants, 6.29% feel that it is caused by a chemical imbalance in the brain, 3.97% feel it is the will of God, 1.82% think it is caused by demonic possession, 7.78% think the cause is drug or alcohol addiction. 3.97% think it’s caused by ‘evil eye’ and 3.31% believe it is caused by sorcery.

Furthermore, 59.15% of respondents agreed that the best way to deal with phobias, fears and anxiety is to face them, 11.97% disagreed, and 28.87% stated that they did not know.

As far as treatment for mental health problems is concerned, 49.64% of 139 participants agreed that hospitalisation is not needed to receive treatment, 20.86% of them disagreed, and 29.50% said they did not know. Those who agreed that treatment outside of a hospital is possible outlined some of the ways that this can be done, including receiving social support from family and community, going to a clinic, going on outings or trips, receiving counselling, undergoing cognitive behavioural therapy, and being around other people.

When they were asked who they would be comfortable discussing their mental health issue or that of a family member with, 38.60% mentioned a professional who could be a doctor, nurse or psychologist, 4.09% said a religious leader like their priest/reverent, Sheikh/Imam, 25.73%

would discuss it with their parents/partner/ family member, 20.47% would talk to their best friend about it, while 11.11% would speak to no one.

In response to the question asking if people with mental health issues should be under supervision in a specialised institution, 38.05% of the participants agreed, 39.82% disagreed, and 22.12% said they did not know.

Regarding the issue of what a person with mental health issues can or cannot do, 11.04% of the participants said they cannot work, 16.23% said they cannot have a partner, 8.44% said they cannot have children, and 4.55% said they are not capable of true friendship. Another 4.55% of the participants think they are very dangerous, 9.09% said they should not be allowed to make decisions, and 1.30% believe they will never recover. Of all the participants who answered, 9.09% supported everything mentioned above about a person with mental health issues, and 36.36% did not agree with any of the above.

When the participants were asked what they thought the cultural image is of a man who suffers from mental health issues, 37.58% of them said he is need of professional help, 9.70% said he is pretending so as to seek attention or to avoid responsibilities, 13.94% said he is someone who is weak and stupid; “a sissy”, 23.03% said he will be seen as crazy, while 15.76% said he will be thought of as dangerous.

The images described above were said to have been obtained from media and social media by 26.00% of the participants who answered this question, 22.67% said from family and friends, 2.00% from religious institutes (church/Masjid) and 49.33% said it was the general view of the community.

When they were asked what Schizophrenia is, 0.89% out of the respondents said it was demonic possession, 26.79% said it’s a split of the mind—having two or more personalities in one body, 44.64% said it’s an illness where a person hears voices due to a chemical and neurological

imbalance in the brain, 0.89% of the respondents felt that it's epilepsy, and 26.79% were not sure.

The participants were asked what they thought are the most common barriers for people of Arabic-speaking background to identify mental health issues and to access support services; 20.46% said that it was lack of knowledge about mental health and services, 2.31% said it was because mental health issues are all in the person's head, 5.76% said the barrier was caused by a lack of support from their community, i.e., leaders and family, and 11.82% of the respondents felt it was a lack of knowledge about available services and support. A further 8.56% said it was a lack of local networks to help with accessing support, 2.88% said it was due to service eligibility issues, 7.78% thought it was due to limited financial means to access support services, 8.93% of the respondents felt the barrier was caused by a lack of trust in the services provided, and 14.70% said the stigma associated with psychosocial problems and seeking help was also a barrier. Another barrier mentioned was the lack of culturally appropriate service delivery, which was supported by 6.34% of the respondents, 4.61% of respondents said the fact that it's not something people talk was a barrier, while 0.86% of them suggested other barriers.

The question about what would help to address these barriers in a culturally appropriate way was answered in the following way; some said changing the mentality of people would help, talking more about it, education and awareness campaigns in the community and cultural and religious leaders, respecting the affected people, talking to them. Some other suggestions were to correct perception of mental illness which is caused by biological reasons; involving the government, make the support facilities easily available in terms of price and location. Also creating awareness from an early age is one way to address these barriers.

When answering this question, what is the best word to describe a person who is sane, in Arabic? Arabic Words such (طبيعي, متزن عقلا وصاحي) (normal, lucky, mashed, awake and wise came up.

The respondents were also asked what their recommendations were to help improve understanding of mental health in the Arabic community. There were at least 80 useful suggestions, mostly written in Arabic. Examples included comments such as "keep speaking up about it because it's hard to change tons of stupid people's mentality", "do more education and awareness through training programs, seminars and campaigns in order to teach parents and family members on factors that affect mental health", "target young people with training at a young age as training can also be done through social networks", and "teaching it as a subject in schools, and through mainstream media". Suggestions like "starting a new philosophy and providing more services that are dedicated to the Arab community" also came up. Also "cooperation between the practitioners and government will improve the situation and also making these type of services at an acceptable price range there are countries where the first visit for consultation costs over SR 500 (\$180)", and others which I will be talking about more in the recommendations section in Chapter 7. A copy of the online survey with detailed graphs is found in Appendix 7).

As mentioned in Chapter 3, the Methodology section, some of the interview participants were recruited through the online survey to elaborate on their answers, and others were found through different snowballing methods. I conducted 20 interviews with 21 people; all the interviews were with a single participant, except for one interview that was with a family, as shown in Table 1.

Table 1. Interview participants and pseudonyms

Pseudonyms	Age group	Education level	Gender	Ethnic background	Interview process
1. Aseel	40-50	Undergraduate	F	Indonesian-Saudi	Single
2. Rania	30-40	Undergraduate	F	Bedouin-Saudi	Family (Daughter)

3. Abo Ahmad	70-80	Highschool	M	Bedouin-Saudi	Family (Father)
4. Asma	30-40	Postgraduate	F	Hijazi-Saudi	Single
5. Amenah	30-40	Postgraduate	F	Bedouin-Saudi	Single
6. Ali	30-40	Postgraduate	M	Saudi	Single
7. Monira	25-30	Postgraduate	F	Arterian-Saudi	Single
8. Roqaya	30-40	Postgraduate	F	Egyptian-Saudi	Single
9. Jamilah	30-40	Postgraduate	F	Australian-Kuwaiti	Single
10. Abdo	40-50	Postgraduate	M	Hijazi-Saudi	Single
11. Khalid	40-50	Postgraduate	M	African-Saudi	single
12. Mahdi	40-50	Postgraduate	M	Iraqi	single
13. Alya	30-40	Undergraduate	F	Yamani-Saudi	Single
14. Omnia	30-40	Undergraduate	F	Bahraini-Saudi	Single
15. Sana	30-40	Highschool	F	Saudi	Single
16. Sama	30-40	Undergraduate	F	Saudi	Single
17. Mohammad	40-50	Undergraduate	M	Lebanon	Single
18. Waheeba	20-30	Highschool	F	Saudi	Single
19. Aydah	30-40	Highschool	F	Saudi	Single
20. Mona	25-30	Postgraduate	F	Saudi	Single
21. Abo Ameen	40-50	Postgraduate	M	Australian-Lebanese	single

5.3 Exploring perspectives, attitudes, beliefs, values and perceptions towards mental health

After talking about the participants in the previous section, the factors influencing/shaping the participants' values, attitudes and belief towards mental health are explored drawing on the online survey and interviews data. The raw data are presented in the previous section. Hence this section is to analyse these concepts, beliefs and perspectives.

I have learnt from the literature that people have their individual way of forming cultural experiences through concepts, beliefs and perspectives, which will influence/shape their attitudes towards anything (Carey, 2009). So looking at concepts first, they are the constituents of ideas thoughts. We form our cognition, or the point of view perhaps, through concept, which is a psychological process that involves, categorisation, thinking (thoughts), memory-storing, decision-making and learning (Margolis & Laurence, 1999). Many scholars debated and explained the meaning and formation of concepts. For example, theory wise, people build and export their own concepts, their own ideas and thoughts, through cognition process. Thus, the representational theory of the mind (Sterelny, 1990) relates the making up of concepts with beliefs, which a stronger internally embedded virtue "Concepts are psychological entities, taking as its starting point the representational theory of the mind (RTM). According to RTM, thinking occurs in an internal system of representation. Beliefs and desires and other propositional attitudes enter into mental processes as internal symbols. Hence, to theoretically understand how people form their concepts or views toward mental health, the literature has spoken volumes about it from a psychological point of view, a theoretical concept. I also asked the research participants about their concepts and views of mental health, drawing on their development of concepts through beliefs, following Sterelny's (1990) theory.

Understanding people's cultural beliefs in this research was paramount to exploring how they perceive mental health. In order to explore their beliefs, the online survey participants were

asked what the term ‘Mental Health’ means to them. The results are graphed in Figure 3 and categorised in Table 2.

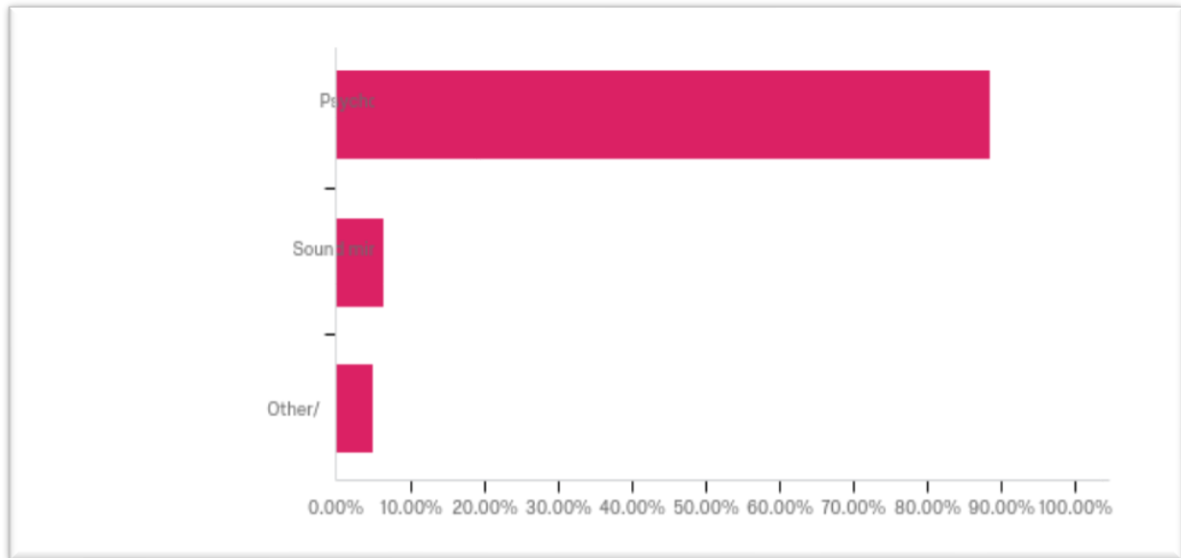


Figure 3. Responses to Question 13 – What does ‘Mental Health’ mean to you ?
 للصحة “ما الذي يعني لك صطلح
 في فلسفي العقلية

Table 2. Online survey responders understanding of ‘Mental Health’

#	What does the term “Mental Health” mean to you? ما الذي يعني لك صطلح الصحّة ؟- Selected Choice	Percentage
1	Psychological well-being/صحّة فاشخص النفسية	88.57%
2	Sound mind; not mentally ill/عقل ليس مجنون	6.43%
3	Other/أخرى	5.00%

Two important views were explored about the concept of mental health. The first view explored was psychological well-being/صحّة فاشخص النفسية, which is a comprehensive, holistic understanding in Arabic about normality, belonging, and total psychological, physical and social health and wellbeing. The second view refers specifically to the “health of the mind”,

meaning sanity and the sound mind. It could be debated which one would explain the responses to the survey question. However, from an insider-outsider point of view, the health of the mind in Arabic "صحة العقل" will be a better term to talk about mental health or illness. It shows a slightly developed literacy regarding mental health where 88% considered it as 'the holistic health of the person', which could be true to some extent; eastern and western medicine have recently started incorporating the holistic health notion and how health is about 'mind, body and spirit' which some studies have proven is important, such as Wilson, Owens and Schaeffer (2018), who studied the holistic usefulness of yoga, meditation and aquapuncture with cancer patients.

However, looking at the answers from the survey, they were reflecting to how the participants form their concept of "mental health" "الصحة النفسية" whether it is the representational theory of the mind, our childhood memories, or what we went through as children; looking at concept and beliefs, takes me back to the early stages of building ideas and "thinking" about meanings for different phenomena. I will give you an example, you might find even a similar memory to mine; I remember as a child I was attacked by a bullying neighbour who smashed an old fashion cokebottle on my forehead when I refused to give her my toy; these memories have developed my concepts, I feel and understand the complex creation of empathy going back to the roots of minute details and memories of these concepts, like relationships, protecting my belongings, the concept of self-protection and the concept of bullying and aggression, and how the scar on the side of my forehead reminds me of these concepts sometimes when I look in the mirror.

Hence, building our perceptions and understanding of feelings, and/or concepts in life, or in these research concepts of health is part of how we view things as adults. This has been apparent in the concepts of mental health the participants shared.

Looking closely into the concepts of mental health, I started analysing the community's understanding of mental health, through their childhood journey, their life experiences before

arriving to Australia, their childhood memories or through their parents or community they lived in, how they formed the meaning, ideas and beliefs they hold towards mental health and would not be surprised when I tell people “I am a mental health educator and consoler” and they often say:

“موتعني علم النفس” “*Is mental health the same like psychology?*” (Hoda, Saudi F)

This is something that I have been asked at most of my mental health education sessions and workshops. It is also something I was confused about in the early years of studying psychotherapy. In order to build on the concepts of mental health and psychology, the difference must be explained, and especially the difference in Arabic. Most Saudi schools teach the Western definition of psychology, which appears in the Cambridge dictionary as “the scientific study of the way the human mind works and how it influences behaviour, or the impact of a particular person’s character on their behaviour”. This may be obvious to many people, particularly to Anglo-Saxons, but “علم النفس” in Arabic is something people do not mention very often, unless they are studying it, have a family member/friend who is a licenced practitioner, or they have had to seek help due to severe mental illness, which is one of the themes I will be analysing next. Arabs, in general, avoid talking about their psychological health, due to their perception of normal, sane and human, which I will explain further on in this chapter (Alkerwani, 2001).

“*Elm alnafss* علم النفس” in the Arab world is also an area of study, the of meaning “elm alnafss” is made of two words, firstly is “elm علم” sense of knowledge and “Nafes” (نفس) which is an Arabic word and has an ancient meaning originally, occurring in the Quran and also defend as “self”, “psyche”, “ego” or “soul”; concept-wise or Quranic concept per se. The root *nūn fā sīn* (ن ف س) occurs 298 times in the Quran, in derived forms 295 times as the noun *nafss* (نفس). The noun *nafss* has been mentioned in the Quran such as the following: “O you who have believed, upon you is [responsibility for] yourselves... The word *nafss*, as used in the

Quran, was mainly to implant a sense of individual responsibility through a strong emphasis on the individual choices while reminding Muslims of their natural human self. Hence, exploring the concepts of “*elm alnafss* نفوس” from an Arabic religious meaning (Muslims mainly) sounds essential given that most of the participants are Muslims and the majority of Arabic speakers in the world are Muslims. The Quran puts great emphasis on the “*nafs*” of an individual by explaining the importance of free will and choice which, according to the Islamic teachings, are an essential part of the virtue of humans, and cannot exist without responsibility and accountability.

Hence, according to the prominent Muslim scholar and philosopher Muhammad Iqbal (2002) “the Quran does not attribute to the *nafs* any inherent properties of good or evil, but instead conveys the idea that it is something which has to be nurtured and self-regulated, so that it can progress into becoming ‘good’ through its thoughts and actions”. He explains “*nafs*” from an Islamic concept of The Quran as having a modernistic undertone and meaning.

On the other hand, mental health in general, as mentioned in Chapter 4, is fairly a Western concept stem from a clinical understanding of the health of the mind, which started in 1883 in Europe and the USA. Although Okasha and Okasha (2000) argued that mental health was introduced through ancient Egyptians c. 1550 BCE in the “Ebers Papyrus” mentioning depression and mental disorders or illness in general, at that time, many countries had not formed yet. Hence, no understanding or a concept of mental health, nor a cultural view about the health of the mind was shaped (Awaad, 2003). Since then, this western knowledge has developed rapidly through the years, compared to non-western communities, yet, even western communities like Australia for example, still facing mental health literacy and the stigma associated with it (Jorm et al., 1997).

5.3.1 The role of mental health education and age in understanding the mental health concept

The role of informal and formal education in mental health understanding has been widely studied (Kitchener & Jorm, 2002). Studying at university, TAFE or workshops that support services organise has reinforced the mental health culture among participants.

Although many of the participants in this research experience mental health literacy and they did not perceive it as “*elm alnafss* غم النفس“, I found that interestingly, some of the participants were able to recognise the concept of mental health within themselves or the community, all of them were tertiary students like “Amenah” who is a Saudi female university student. She stated that:

“The awareness about mental health problems is what people may experience or understand. And so, I can tell you from my own perspective that the differentiation of someone’s knowledge and understanding is related to their level of education. For instance, I do recognise that people who have a Bachelor university degree could have more knowledge about it, but those who have less could act in some form of fear, or they ignore the situation as a whole.”
(Amenah, Saudi F)

The view above is confirmed by many participants, as part of the normal cultural through the interviews dialogue about what may seem unrelated to the research; for example, “when did you arrive in Australia? How do you like it here? Have you been to that Arabic lamb place near you?” These questions have helped me to understand their beliefs and concepts and how they view mental health. When I wonder how they perceive mental health, I realised that they are more open to discussing mental health in comparison to some of “Elderly” participants and people with a lower level of education who may have less knowledge about mental health.

University students have better knowledge about mental health as many scholars argued, they have more openness to seek understanding of any new phenomena or even changed their attitudes to concepts they know or experience (Eisenberg, Golberstein & Gollust, 2007).

That kind of thing (knowledge about mental health) has been apparent to me during my study. I mean, with the pressure, especially throughout my Bachelor's degree, I began to discover that I need to read on that thing (mental health), to help me manage study and become excellent, and so I began the journey with a small book from Jarir book store. I used to always go to buy books that are not related to my study area, and I always like the self-awareness and mental health section. (Amenah, Saudi F)

Amenah also emphasised the role of education in understanding the concept of mental health. However, some people believe there is reluctance in the community to accept mental health.

We can't deny their existence, the effect on us. This is very important to note, that we, as a community, don't believe in psychological problems or mental health issues. (Aseel, Saudi F)

We all have our own distinct values, beliefs system and attitudes, which influence the way we think and behave. They influence the way we understand and form a judgment about different things and is developed throughout the course of our lives (Carey, 2009; Margolis & Laurence, 1999). In the Arabic-speaking community, our family, friends, peers and our experiences contribute to our perception of who we are and how we understand concepts around us (McGoldrick, Giordano & Garcia-Preto, 2005). Our way of thinking and our attitudes are formed according to our past experiences and factors like the stories we hear about good or evil, the stories we hear about values similar to what some of the participants had reported. The participants expressed different attitudes towards mental health as a concept and different attitudes towards people who experience mental health issues.

Many of the participants made a strong point of reference when it comes to negative attitude and receptions towards mental health; it certainly confirmed what many participants expressed on the negative attitude of the Arabic community towards mental health. As one of the participants mentioned:

Three-quarters of the society and I can swear that they do have a negative attitude towards mental health and people affected by them, and that is so dysfunctional from my own experience. (Abo Ahmad, Elderly Saudi M)

Two other participants shared the same view; Alya, who is a young Yemeni-Saudi female and Mahdi, who is a middle-aged Iraqi male. However, I always felt uneasy about how some people have such negative attitudes towards people who experience mental health issues, from a very young age. Through this research, I recognised that this was built up through culture, and part of that was the folk story like for example, the story of Aboqureena that I will be sharing in the next chapter.

In the online survey, I asked the participants what their attitudes were towards a person with mental health issues who appears in the news or on social media. Their responses are shown in Figure 4.

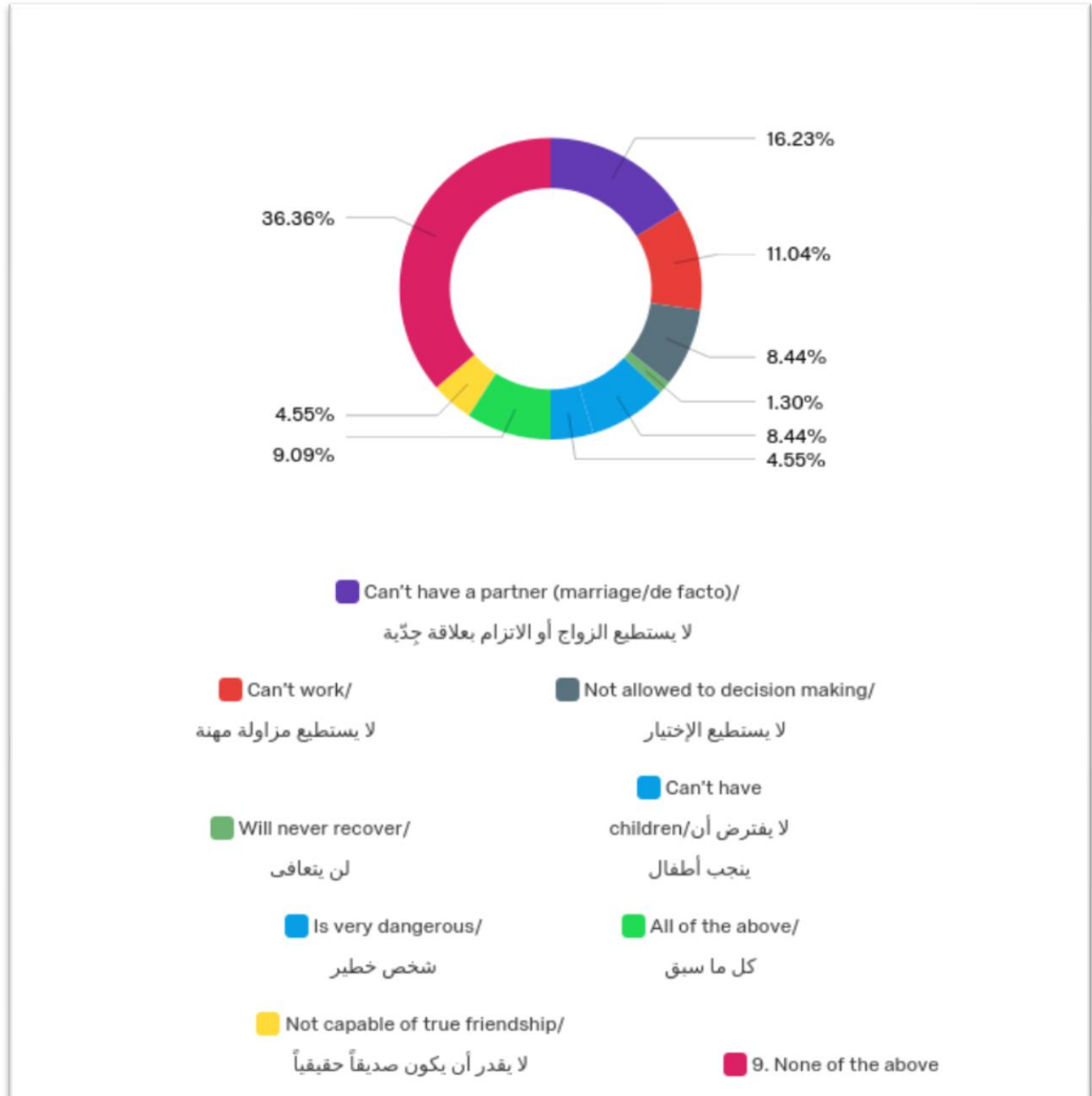


Figure 4. Survey Question 28 – Opinions about people with mental health issues

The question above raises two important questions: “What are the beliefs behind this attitude?” and “What are the values they hold towards mental health and people who are affected by it?”

To try to unpack this, one of the survey questions was: “What is the best word to describe a person who is sane, in Arabic?” ما هي أفضل كلمة لوصف شخص عاقل في اللغة العربية؟. Sanity in Arabic is “a’aqel عاقل”, which is mainly translated to “sane” or a “sound mind”.

This question received numerous different Arabic words in response, including دمي، رالكز، عاقل رالكز, raked: stable and Adami: human. Adami refers to the Islamic belief, which is shared by many other religions, that Adam was the first human, so the human race is “Adami”. If one of the main points of being a human is who you are in your mind, if your mind is not sound, you are not human.

In an interview with Jamilah, an Australian-Kuwaiti female, she said:

They are not looked at as having a mental health issue, they promote it as it is a crazy person, so they are less of a human being in a way.

Sana, who is a Saudi female, agreed with this point. Stigma plays a major role when dealing with mental health- which is explained more in Chapter 6- as stigma marks a person as ‘different’. The World Health Organisation (2001) defines stigma as “a mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society. Scambler (1998) describes stigma as “...any attribute, trait, or disorder that marks an individual as being unacceptably different from the ‘normal’ people with whom he or she interacts, and elicits some form of community sanction” (p.1045). The biggest reason behind a lack of mental health literacy is stigma (Jorm, 2012),

This leads to the question: How do people feel about seeking help? What are their attitudes towards seeking help? I asked this question in my survey and in the interview, but I was concerned that if people are not aware of the problem or the mental health issues per se, how would they have an “attitude” towards asking for help? How would they want to solve a problem if they know nothing about it (that is about 30% of the people who responded to the survey), do not understand it or willfully ignoring it? I will explore the findings in the next section.

5.4 Wilful blindness between literacy and ignorance (the unmentionable *ما لا يقال عنه*)

Many of the participants expressed their views on mental health as “the unmentionable *ما لا يقال عنه*”. People don’t talk about mental health or illness. The community has this set of rules about what can be discussed and what is off the table. This is due to many factors, including cultural norms and mental health literacy (Hamid & Furnham, 2012), and whether people are willing to deliberately be ignorant about mental health in order to fit into their community. Most of the participants have grown up in a different culture to where they are now residing, as most people from Arabic-speaking backgrounds have grown up in culturally conservative societies (Al-Krenawi, 2014). This was apparent from their stories.

It is presumed that you understand that certain expectations are placed upon you in conservative societies – coming from one myself- particularly in the way health or mental health is perceived. You are forced in some cases to think, or not think, in a certain way to gain the approval of the group or the community. This means putting people who “believe” in or accept mental health issues or illness in a category of people who are abnormal, and they might be labelled, shamed, excluded from community and religious gatherings. Community elders, who are considered as the leaders by default, are more inclined to identify mental illness as socially unmentionable, but still, many young and old go to the extent that they believe that mental health issues such as depression are a form of mental retardation (Wilson & Neville, 2009). Some participants view mental health or illness as a lack of moral courage and integrity or a lack of faith. Other participants think that ignorance is a blessing “*الجاهل منعم*” and that it is probably safer not to mention it. This idea of ignorance was discussed by other researchers such as Morris (2001) and was also expressed by some of the research participants.

I think that in our society it is unmentionable, they don’t say much about it, mental health, but because we have been raised there, our awareness will always be not sufficient about mental health. When I came here, Australia, I knew a lot about it, and

I felt I could openly talk about it. But back home in my family, my father had a diagnosed serious mental illness, we were told it is to be private and only us, the family, to discuss, and the community or extended family, will never be accepting. They see it as a human being who is 'faulty' or incomplete. (Jamilah, Australian-Kuwaiti F)

The lack of support and understanding from the greater community might also be a challenge for people who are more informed about mental health and suffer from some type of mental issue. Simply accepting their fate and viewing the issue as “Gada wa Gadar وقدره” (God’s will) could be very difficult.

Through the findings in this research, it is apparent, people may choose to ignore the severity of their mental illness of the facts about the medicines they are prescribed or even the fact that this may be an act of jinn or sorcery the law terminology that uses willful blindness, that depending on their awareness and level of education

As a practitioner, I have been interested in knowing why people ignore mental health and why it is unmentionable. I came across many people from Iraq, Lebanon, Syria, Saudi and Yemen through my work as a mental health educator who would say “mental health is not something we talk about”. This statement makes me wonder why literary and mental health disparities play a major role. You cannot expect people to talk about something they do not understand or fear. In the interview, the participants were asked, “How does the Arabic community perceive mental health issues? “How do they perceive or talk about psychological problems?” In general, the answers were diverse. For example, Asma commented:

It depends, it differs from one person to another if we talk about it in Australia, especially with Arabic immigrants. They could've known somebody with a psychological illness, but they don't respect them, they don't show them understanding.

It's even possible that they don't give them a fair chance to be, or an appropriate living arrangement, like family.

What Asma referred to is common within Saudi community. Many of the participants shared experiences with living among traditional families ;and although it is normal that families go through hardships and struggles they would be “warned” by parent to not disclose any personal matters, this experience was something I could relate to growing up in Saudi. However, as mentioned before in the literature review ‘ among Arabs generally, it is the norm not to disclose family issues or psychological problems; it is considered to be “unmentionable” (Haj-Yahia, 1995). Many people in the community will prefer to deal with their emotional problems in secret of course, due to shame and stigma (Al-Krenawi & Graham, 2000a), which is a major theme throughout this research and is covered in more depth in Chapter 6. The important role of the family may enrich people’s life by offering them an extended network of emotional support and guidance when facing any social issues (McGoldrick, Giordano & Garcia-Preto, 2005). However, some of the participants expressed otherwise, including Zena, a 31-year-old Saudi female, who said:

I think they try to isolate the mental health issue, but they don't let a lot of people know about it. It is unmentionable, we don't talk about it, we keep it quiet.

This sentiment was shared by various participants. Others felt that due to the cultural expectations, mental health issues would not be acknowledged or talked about outside of the family, but the family could be called upon for support.

I think people are not going to say, for example, that my sister came to me and said, “I'm sad or depressed”. Also, nobody is going to tell her to go to a psychologist, the condition doesn't require an outsider's support, the family can support her. (Alya, Saudi-Yamani, F)

Abo Ameen, an Australian-Lebanese middle-aged male who is considered a Muslim leader and a source of advice to many community members, said:

They might not disclose to others, they don't feel completely comfortable, particularly because we're talking about mental health and we all know that there is a stigma attached to it in any society, let alone the Middle-Eastern community.

Moreover, in the online survey, 23% of the participants responded, “we don't talk about it (unmentionable)” in response to the question regarding other common barriers to people of Arabic background identifying mental health issues.

In your opinion, what are the most common barriers for people of Arabic background to identify mental health issues & access support services?

ببرطانيك ، ما هي ال عوطيق المتشيع شيوع

الوقت يي واجهه ا؟؟ اص من اصل عربي لك حيدم شكلك لاصح على لية وال حصول على خدمات الادع؟

But we know from the literature that literacy around mental health issues is a major influencing aspect in informing people about their wellbeing and will also affect their attitudes towards talking about mental health (Al-Krenawi et al., 2009)), which will lead to being “unmentionable”. After all, people are not expected to talk about something they don't really understand, which was discussed in details in the literature review around mental health literacy.

5.5 Mental illness or Mjnoon (مجنون crazy)

The word “Majnoon مجنون” occurred to a great extent throughout the interviews and the survey. The term not only describes the way people perceive someone with mental health issues, but it is also a significant aspect of the “fear” people hold towards mental health issues, to avoid being called “crazy”. Stigma is one of the biggest burdens people carry, which will hinder their acknowledgment and understanding of mental health issues (Youssef & Deane, 2006). But it

is not new, or uncommon, that many people, not only Arabs, call anyone with “abnormal” behaviour or thinking as crazy, cray cray, or “Majnoon مجنون”; it is also reported by scholars like Wahl & Roth (1982). It is a significant aspect of labelling and stigma, which I will be talking about in mental health literacy inflecting factors in the next chapter. “Majnoon مجنون” in this section of the chapter, will be discussed and explored through the words of the participant, and how culturally and religiously “Majnoon مجنون” is a term used in many contexts in Arabic.

The reader may have come across “Lila and the Mjnoon” as it was future on the “princess theatre this year 2018 in Melbourne, or may have read the love story of “Majnoon” Lila (Qusai Ibn Almolweh) a very famous Arabic Bedouin poet, which his story is well-known across the Arab world (Albinali, 2013). *Qusai Ibn Almolweh* fell in love with Lila, and due to her family’s rejection, according to the story, he “lost his mind” and started roaming the deserts writing love poems about Lila. The story is famous in Arabic literature as well as in Arab folk stories, which plays a major role in the way people make sense of “Majnoon” or in some case “mentally ill” in most Arabic-speaking communities.

One significant reference and maybe the first one I knew while learning in school about Islam was:

”وَعَنْ النَّبِيِّ ﷺ قَالَ وَعَنْ الْأَمِّ مَخْجُونٌ وَعَنْ الصَّبِيِّ عَقِيمٌ وَعَنْ الْمَخْجُونِ عَقِيمٌ”

The Prophet Muhammad (ﷺ) said: There are three (persons) whose actions are not judged (their deeds) by Allah: a sleeper till he awakes, a child till they reach puberty, and a “Majnoon” (insane) till he comes to reason.

This “Hadeeth” is consequentially a reference to mental health in the Islamic context; the way it is perceived in a religious context, and the binding cultural and religious norms. To unpack this “Hadeeth”, the word “Majnoon” or “Majun” translates and refers to madness, insanity,

crazy or even abnormal. The term derived from the word “Jinan”, and it has several meanings in Arabic, the distinct meaning of I am, but looking at the Arabic origin of it as: cover of the mind, a total or partial absence of mind’s functionality, or the forms of abnormal behaviour, according to the Al-Mawrid Arabic dictionary (Ba‘labakkī & Ba‘labakkī, 2001).

It is noteworthy that some participants perceived anyone with mental health issues as “majnoon”, but the attitude and meanings towards someone who is “Majnoon” were different. Considering the meaning with reference to the *Hadeeth* above, some of the participants view “Majnoon مجنون” as a “hindrance” to justice or capability in the community or they feel they are not fit to be a law-abiding citizen. Sheikh Abo Ameen, who was part of the advisory experts' group, said:

... I think that from my experience, Arabs generally, when something related to the “Aql العقل mental” in any form, even when you talk, and use the word mental, they’re gonna stop, because we have some restrictions from the logical and practical point of view; and the social point of view. An example, from the logical point of view, if you come to a Sharia law court, for any issue, and you are a person with any record that says you have a mental issue, you will be disregarded as a witness.

This statement highlights a similarity in Australian law courts, where the testimony of a witness, for example, can be disregarded if they have a history of mental ill-health that may affect their thinking or judgment. Moreover, many Arabs view someone who has mental health issues as “Majnoon” and unfit to serve in the justice system or take their place in society, which is an important aspect of belonging in the Arabic community. To be labelled as “Majnoon” means that your actions will not be judged as you are not regarded as sane. Abo Ameen said:

From the religious point of view, there are complications. If someone was in court under sharia law in the Middle East, they would not be prosecuted due to “Adalah and

Takleef” which is justice and commissioning, as in Islam you are judged by Allah only if you are completely aware.

In more recent times, many countries that follow Sharia law, like Saudi Arabia, consider the testimony of a person with mental health issues as not binding, accepted or counted. If they commit a crime while they are suffering from mental health issues, they are not going to be prosecuted but will be placed in a psychiatric unit, similar to the Australian law system. The point of discussion in this is to highlight the way “Majnoon مجنون” is viewed by the community, including some of the participants, who described this as what people would call you if you suffered from mental health issues. It made me think about how people feel around family and friends when talking about “Jonoon”. And how they feel when hearing someone talking about mental health, or for example, a case they saw on the TV or heard about. As some of the participants expressed:

People don’t want to be called crazy or be judged. (Amenah)

They say Nafsyah (psychopathic), “Taralllay”(crazy), “Majoon” crazy. (Mahdi)

They are called Majnoon (crazy) immediately. (Zena).

Another participant recalls:

My mom told me, “Don’t tell anyone that your dad has a mental health issue because no one will marry a girl whose father is crazy”. (Roqiaya, Egyptian-Saudi F).

Growing up in Saudi it was not unusual to be categorised as either healthy or “Majnoon”. People who experience mental illness are often cared for in the privacy of their family’s home rather than being sent to a mental health professional. Mental health issues and even stress or fear are often expressed through physical symptoms such as headaches or stomach aches that are explained by Western psychiatry as ‘Somatic mental health symptoms’. This is an acceptable way to express distress in the Arabic-speaking community where psychological

problems are stigmatising, and people who sufferer are at risk of being labelled as “Majnoon”. Hence, consciously physical symptoms such as fatigue and or aches and pains are more legitimate and acceptable than “Majnoon”.

Roqiayah, who is an Egyptian -Saudi female, said:

The mental illness has a physical illness and bodily pains, my father always says I have pains that due to the extreme anxiety he suffers from, when had had panic attacks he become spastic and he had pains in his body, they -the family members-were saying to him that you have “Maraad مرض” illness in your body only, but I knew it’s not, when someone is physically ill they feel it only in their body, but they will not be mentally confused and anxious.

It is a distinct discretion to people who have mental health issues to be called “Majoon”, during the interview almost all the participants said “Majoon” immediately when I asked them about some words that people use in Arabic to describe someone with mental health issues, and as Al-Darmaki, Thomas, and Yaaqeib (2016, p. 236) argued, “Associating craziness with mental disorders is not surprising in Arab cultures”. But even when someone overcomes their fear of stigma and tries to explain their mental health issues, it is still considered not wise, and many people will be judgmental.

Roqiayah also expressed her view by saying:

My dad used to say, “I become afraid when I have panic attacks”. He used to say, “I’m extremely depressed, I have severe depression” when he was trying to explain his illness and really who he is. He wasn’t ashamed about his mental illness. Our family members were describing him as Majnoon, hallucinating, possessed “Mas’hoor مسحور” accusing him with things with that have nothing to do with what is he suffering from or how he feels.

Another participant agreed, saying:

People will call you “majnoon” if you are depressed. This shows that even when they are aware of a mental health challenge, they prefer to hide it with the fear of being judged. (Khalid, Saudi, M)

5.6 The role of Qada wa Qadar (قضاء وقدر) destiny and fate)

It was quite interesting to hear the participants talk about “Qada wa Qadar (قضاء وقدر) when they were asked about how they perceived mental health.

There is a fundamental issue underlying mental health. When you raise it you think about the social perspective so, you know, as Muslims, we believe in fatalism. We believe our future is pre-determined, but what does that mean in the case of mental health and seeking help. In some cases, that means that we don't seek help, for example, a person, say, my child, has this condition, bad mental health. God has given him that, that's his Naseeb (نصيب) (destiny or fate), that's what God has given him, so you accept that and then from then on, you don't go to seek help because you believe this condition is out of your control, which is known as external loss of control. This is beyond my control. God gave my child this condition, there must be some great reason why he has it. So then I don't need to follow up too much, it is what it is, basically. (Jamilah)

“Qada WA Qadar (قضاء وقدر) "Naseeb" (نصيب) and/or “Maktoob (مكتوب)” refers to the way people accept and submit to God's will. The religious understanding of faith “إيمان” in Islam, defines this as “believing in God's broad knowledge everything, as a core value to be a believer”. Any child growing up in Saudi will be taught about “belief إيمان” as God's absolute knowledge of the past and the future, it is about having faith and certainty that God has “written” all the creatures' destiny and fate, from the moment of birth until the day of Resurrection. We were told that to be a believer, one must believe in fate and destiny, whether it is good or bad. I found this belief occasionally surfacing through the interviews, as it was embedded in the participants

from a very early age. Moreover, this concept is not unique to Islam, as people from many different backgrounds who believe in some form of deity will fall back on this concept of destiny when affected by mental health issues that leave them feeling vulnerable and with little power or control (Wilt, Exline, Grubbs, Park, & Pargament, 2016).

Arabs from a Muslim background believe in fatalism and destiny (Wilt et al., 2016), which was explored in the survey in an effort to understand whether the belief that life is predetermined by God is a reason that people have a negative attitude towards mental health. Participants were asked how fate and destiny play a role when people encounter mental health issues and where it stands from their perceptions and understanding about mental health. Of the survey respondents, 16.9% believe mental illness is God's will 'Qada wa Qadar قضاء وقدر and it is certainly the case with some of the participants that a person's understanding of God's role in their health, including mental health, is likely to play a significant role in how they perceive mental health issues. I also tried to ask if beliefs about God's will and suffering may cause feelings of anger or disappointment towards God, but the participants did not easily share such thoughts.

Several participants identified that religious beliefs are sources of strength and hope, and emphasised that these beliefs can pose barriers to seeking help if mental health issues are encountered. I found that people from the Arabic-speaking community who believe in "God/Gods" display this reliance on God when affected by mental illness, and while working with different migrant and refugee groups in Sydney, mainly Muslims and Christians, I observed that they feel they are left with little responsibility while God is in control of their destiny. The findings of the online survey and comments made by interview participants have aligned with the findings of Wilt et al. (2016).

When reviewing the literature at early stages of this research, I came across a book called *God's role in suffering: Theodicies, divine struggle, and mental health* by Wilt et al. (2016), which

presented a rather challenging point of view. Reading the book took me out of my comfort zone as a believer in Islam and God, along with the fact that I am still finding my own understanding of the “Qada wa Qadar قضاء وقدر” concept through my role as a mental health practitioner and educator of people affected by mental health. This sense of discomfort has helped me in many ways to reflect better on my own epistemology and the frameworks in this research, but more importantly, to reflect on the research participants’ understanding of God’s will in terms of mental health. This book prompted me to ask questions in the interviews such as, “Could the religious view that life is predetermined by God “Qada wa Qadar قضاء وقدر” Nseeb” مكتوب and/or “Maktoob مكتوب”, be a reason that people have a negative attitude towards mental health?” and, “If “Qada wa Qadar قضاء وقدر” means we are helpless, how do you feel about this when you deal with mental health issues?”

Yousef explained the response to the questions as:

Nothing is going to happen to anyone except which God has destined, and so people feel attached to God and his mercy. He permits blessings when you protect yourself by reciting the Qur'an, “nothing is going to hurt you except by God's permission”. Don't you do that? So that Angels protect you ? Recite “almuthat” ? Anything that happens after, it is God's fate & destiny, and it's not related to anger, envy or evil eye.

This “Ayah/ verse” of the Quran that says *لَنْ يَضُرَّكُمْ شَيْءٌ إِلَّا بِإِذْنِ اللَّهِ* (nothing is going to hurt you except by God's permission) is one of the core beliefs Muslims hold through “Qada wa Qadar قضاء وقدر”. Reciting “Almoutat معوذات” is also a part of the religious practices that most Muslims do to protect themselves from evil and sickness (Haque, 2004). Few of the participants agree, like Mona, a Saudi nurse and female who repeated the same verse to me in her interview, but this will be explained further in the next chapter. One of the research participants, who shared her story about living with depression, told me that her partner's reaction was not to

accept her condition, and when I asked her whether he believed in psychological problems she said:

No, not even any sort of medical diagnosis or intervention, he will say sit down and read the Quran, pray, "AthkoryAllah الكري الله" praise God, snap out of it, be patient.

Patience comes from having faith in Allah. (Asma, Saudi F)

This emphasises that religious beliefs offer a real source of hope and comfort to people who are suffering from mental health issues. Many studies conducted into dealing with major life stressors such as natural disasters, illnesses or loss of loved ones, which may be a contributing factor to serious mental illness, have shown that religion or the belief in a higher power significantly helps people to cope with traumas or mental health issues (Abdel-Khalek, 2009; Haque, 2004; Thomas & Ashraf, 2011).

For the participants in this study, their belief in God is an important resource to draw on as it offers them hope and acceptance. It is one important way that many of my research participants view, explain and deal with mental health issues. Traditional religious healing, which will be analysed in the next chapter, is one of the most important approaches people use in an attempt to restore their physical and mental health. We know from the research that spirituality and religion can play a major role in health and wellness for everyone (Thomas & Ashraf, 2011). However, in the Western mental health perspective, it is an area that is usually avoided. An example of this is Freud's view of religion as being "a universal obsessional neurosis", which is quite the opposite of how the participants view Islam.

5.7 Conclusion

The research participants viewed mental health in a way that was inquisitive, confirming the ideas and analyse exploring the "unmentionable, how the topic of mental health is not talked about, whether it is due to the fear of stigma or due to the lack of understanding about mental

health issues. Moreover, the data from the interviews has assured me that some of my participants believe that they are better off being “wilfully blind” in order to keep their position in the community and preserve their profile or “face”. I learnt now for sure, and even with many of the participants who are not strictly religious, they still believe in “Qada wa Qadar قضاء وقدر” as a cultural norm, and that what they are given is their fate. The next chapter will be analysing and sorting the findings to discover why people hold these perspective, views, and beliefs, and present the factors influencing the participants’ understanding of mental illness and the stigma attached to it. I will also explore how believing that mental health is somehow God’s will influences whether they seek professional help, and what religious traditions exist concerning mental health issues and healing.

Chapter 6: Factors contributing to mental health literacy

6.1 Introduction

The previous chapter describes the way participants view and perceive mental health issues based on cultural beliefs and attitudes. In this chapter, I will be unpacking some of the significant factors that contributed to these views and perceptions through the experiences the participants shared. This is in response to a notable gap in the current literature around mental health literacy in the Arabic-speaking community in Australia (Furnham & Hamid, 2014; Tobin, 2000) I discussed this in some detail in Chapter 4 – where applying the findings on non-English speaking communities, like the Arabic-speaking community in Victoria; and how there an underlining lack of a clinical intercultural understanding of mental health, and how this plays a major role in mental health literacy.

This chapter, answers one of the main questions of the research: What are the religious beliefs surrounding mental health issues in the Arabic community? Which includes queries like why people from the community are not accessing clinical Western -e.g. psychiatrists- professional help, which was confirmed by some studies noting the lack of service access by Arabic-speakers (Furnham and Hamid, 2014)

In order to answer this question, the factors contributing to mental health literacy will be explained and analysed through the research participants' views and presented in three separate sections of this chapter: 1) Religious beliefs and Practices, 2) Cultural beliefs and practices, and 3) Traditional and religious healing.

It is noted from Chapter 5 that the participants perceive mental health from a non-western concept. They have shared their understanding of mental health as the “unmentionable”; they agreed that many members of the Arabic-speaking community view a person experiencing mental health issues majoon, they spoke about destiny and fate. These findings are similar other studies around mental health literacy in CALD (Kenny, Mansouri, & Spratt, 2005; Yu, Kowitt,

Fisher, & Li, 2018) and as Youssef & Deane (2006) state, “It is likely that cultural beliefs, shame, stigma, fear of being misunderstood, traditional family structures, traditional support systems, and lack of trust of external providers may all influence mental-health-care utilisation” (p. 48). To unpack the factors and the stories behind these views and perceptions which the participants shared with me, I will be looking at two main themes:

- 1) Religious beliefs and practices behind mental health literacy; Jinn (Djinn), Seher and Rabet; Black magic and spells (sorcery); and Hassad حسد
- 2) Cultural beliefs and practices; Aybe stigma and shame; and manhood, which will lead to the cultural practices and cultural hopes for healing.

Based on what their studies revealed, Jorm (2012) and Kayrouz et al. (2014) have indicated several factors involved in the avoidance of service access. One of the important factors is the lack of recognition of the mental disorder by the person affected, which is caused by a poor or non-existent level of mental health literacy (Jorm, 2000). Some of these studies have highlighted the factors contributing to mental health issues, mental health service access and barriers to seeking mental health support (Aloud & Rathur, 2009; Hamid & Furnham, 2012). However, there is a consensus that mental health literacy is the most important playing factor (Al-Krenawi et al., 2009; Furnham & Hamid, 2014; Han & Pong, 2015; Jorm et al., 1997). This brings me to the core of this research and the main research question: what is the mental health literacy of the Arabic community? And what are the factors causing such perception? In this chapter, I aim to answer these research questions based on the survey, interviews and = autoethnographic experiences observations as a community member, and a researcher.

6.2 Religious beliefs and practices

In a similar study about mental health service access among the Arabic-speakers in Australia, the findings fell into three major categories: perception of mental illness, barriers to utilisation of mental health services, help-seeking preference, alternative treatments and strategies for

improvement. As I mentioned previously in Chapter 1, this research is focusing on the perception of mental illness; the reason for their beliefs and the ways that they deal with it.

Cultural beliefs are strongly intertwined with religious beliefs in the Arabic-speaking community, and it provides a sense of identity for many of the participants; many of them shared similar views when talking about Islam or culture.

In the online survey, I asked about the causes of mental illness; approximately 40% of the respondents thought it was one or more of the following: religious causes, spiritual poverty, not accepting religious leaders' advice, God's will for their lives, failure to adhere to the tenets of God as revealed in the holy books, demonic possession, “Hassad حَسَد” or “Sher” by sorcery. The results appear in Figure 5.

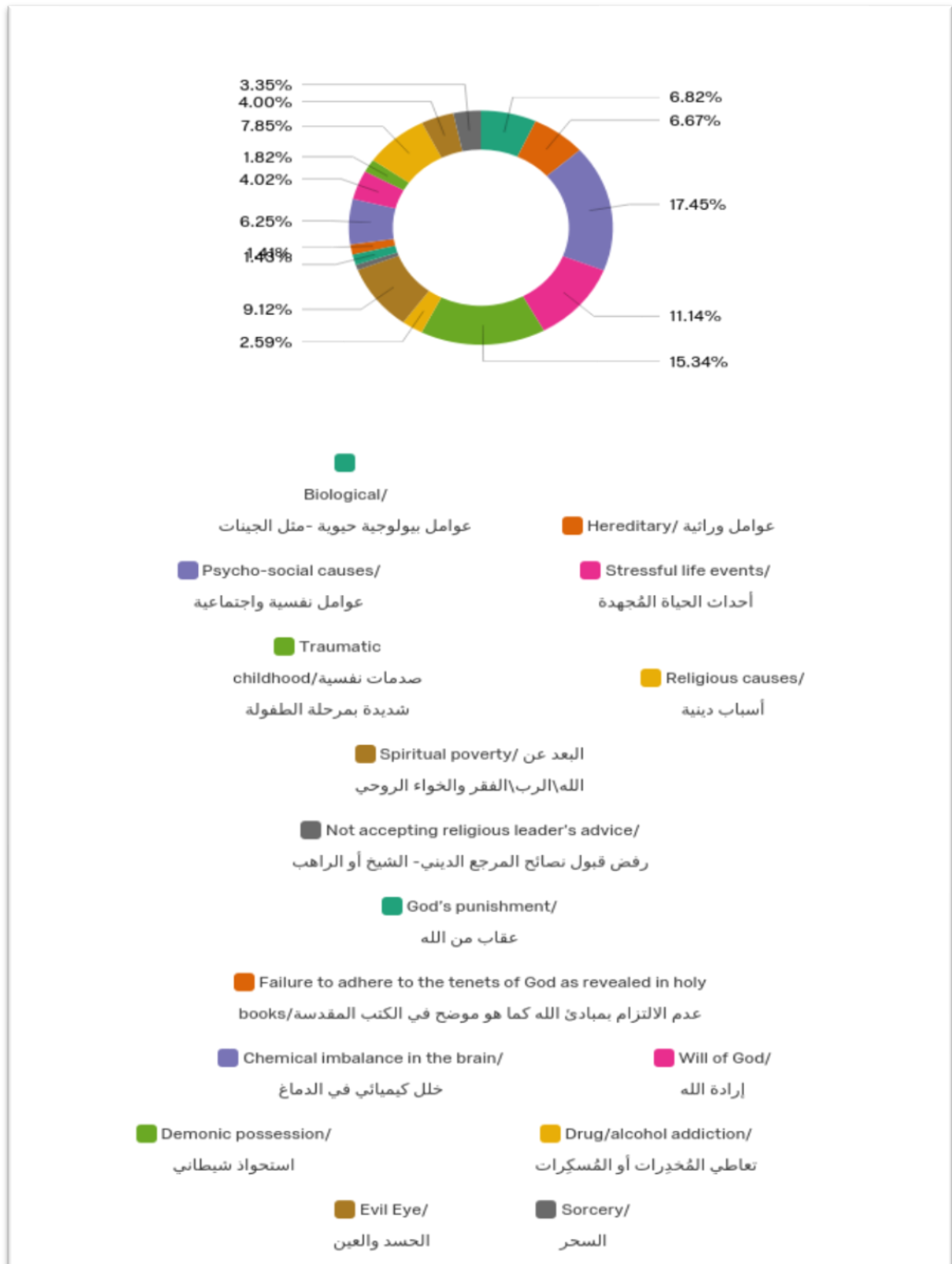


Figure 5. Results of Survey Question 16 – The causes of mental illness

The research participants stated that due to religious /cultural inhibitions, shame and stigma, they see mentioning mental health or seeking support is out of the question. I understood that this is a contributing factor to their understanding of mental health issues. Hence, if they do not understand mental illness, or have their own cultural views about it, they will not necessarily seek support. This finding echoes Minas, Lambert, Kostov, and Boranga (1996), who state that there are a number of possible reasons for service underutilisation. However, these reasons not previously been studied widely in Australian Arabic-speaking communities. However, underutilisation of mental health services within the Arabic-speaking community is related to social restraint and a solid feeling of disgrace and shame inside families that averts or defers a choice to look for western medicinal interventions. Service utilisation and western interventions will be further explained in Chapter 7. A research was conducted to understand the attitudes of 160 people in Yemen aiming to assess their opinions about the characteristics of people with mental health issues, and the treatment options for them (Alzubaidi, et.al,1995). The findings state that more than 60% of participants perceived mental health as an attribute of “Roh alshayta روح الشيطان” which according to the interpretations by Alzubaidi, et al.,1995) translates to “evil soul” and “Shaytan” is Satan in Arabic.

Across the findings in the online survey, many of the participants believed that mental health issues are closely related to religion and culture, and that is the best way to deal with it. Jamilah, who is 32-year-old Australian-Kuwaiti mother, shared a story about a lady who has a mental health issue:

I could recognise the mental health issues, but they didn't see it that way. They, the Arabic-speaking community, didn't perceive her as having a mental health issue, they actually believed that a ghost or a bad spirit or a jinn evil spirit, you know, of the likes of Satan, had gotten into her.

Her story resonates with me. I remember such explanations for people who suffer from mental health issues in the community. One of my aunts was going through marriage problems and in the same year her mother, my grandmother, died followed by my uncle. This was an emotionally tough time for all of us. I recall my mother crying and grieving, but my aunt used to talk to herself, she believed that anyone she loved would leave her. She fluctuated between being so energetic, angry and loud, to being quiet, crying nonstop, and sleepy. At that time, the family either said, “don’t talk about it” or “she is possessed”. I remember the Sheikh coming to the house, and I can hear the Quran being recited in her room. When I came back to Australia, my sister told me that my aunt was diagnosed with depression with delusions, which is a typical symptom for manic depression according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), published by the American Psychiatric Association. It was apparent to me as a practitioner and insider that the whole family lacked understanding about manic depression, and that my aunt suffered for a long time before she was diagnosed and medically treated.

The connection between religion and how mental health was explained was what participants knew as children. The folk stories that some of my participants share relates to the way there have formed these concepts about mental health issues, whether its jinn or sihr.

The following sections will offer definitions of each concept in the following sections, to unpack the participants cultural and religious views accompanied by the related literature to provide a more in-depth analysis of the cultural and religious practices. As it was often important to remind myself about the impact and influence of these religious and cultural factors as they help set the grounds and explain the roots of mental health literacy. They also highlighted many of the non-Western views and explanations behind mental health issues throughout the research and data collection journey.

Many global studies found that the belief in the supernatural as a factor of mental illness is very common in the Arabic-speaking community (Al-Habeeb, A & Qureshi, 2010; Al-Krenawi, 2005; Alqahtani & Salmon, 2008). Aligned with these studies as key themes that emerged from the data collection, are the religious factors that people connected to mental health issues: Jinn, Sihr and Hassad.

According to the Qur'an, God created two parallel species, man and the jinn; the former was created from clay and the latter from fire. Noteworthy is that beliefs about the jinn "are deeply integrated into Muslim culture and religion, and have a constant presence in legends, myths, poetry, and literature" (El-Zein, 2009, p. 1 Abs).

Sihr and Rabet are (سحر وربط) black magic and spells (sorcery), according to Muslim belief. Sihr is inflicting harm on people and objects, which is equal to black magic in English. Rabet is a sort of black magic with the sole intent of inflicting harm on people, according to Algarni, A. (2008), who claims that Sihr in Islam is divided into eight types. His book explains all types extensively; however, I found it hard to get proper definitions and details from literature written in English. Knight's (2016) *Magic In Islam* contains much information, but the book is written in Arabic. I have, therefore, extracted and translated what I can from participants' responses in the interviews.

Hassad حسد (envy or evil eye) is the practice of invoking a curse or harm by casting a malevolent glare and is usually given to a person when they are unaware. In the Islamic context it is more related to jealousy, "Hassad حسد", and Muslims believe Allah will protect them from its effects.

These main themes are explored, analysed and linked to the research participants views surrounding mental health issues in Sections 6.2.1, 6.2.2 and 6.2.3.

6.2.1 Jinn جن (Djinn)

Like many of the research participants, I grew up surrounded by the idea that if you became unwell or insane “Ta’aaba تاعابان and started behaving and acting out of the norm (for example hearing voices) or experienced any other type of mental disturbance, it was due to jinn. It is noted that the concept of Jinn has accumulated widespread acceptance within religious communities through folklore and cultural experiences (Lim, Hoek, & Blom, 2014). Although the idea of referring uncommon behaviours to jinn is certainly not the only way in which the Arabic-speaking community explained causes of mental illness, hallucinations, delusions and other psychosis symptoms.

When I asked Zena, a 31 years old Saudi female about mental health, she stated:

But they don’t believe that it’s about mental illnesses. They link it to other things like Jinn.

Khalid, a Saudi male, confirms the same view by saying:


Perhaps when somebody is “Taban تاعابان, and wiped out and having mental health issues, they will state it’s Hassad or an evil presence, a possession by Jinn. Obviously, jealousy and jinn are altogether referenced in the Quran. I don’t deny their reality. However, perhaps society’s portrayal of the case is wrong. It could be mental problems, and it could be jinn, but you can’t diagnose that unless you are a psychologist. Such cases come and go but do they exist in religion, yes they do, and it’s related to most of our perception as a society. But maybe it’s not a Jinn possession, it could be something else, but our first reaction will be “he is Jinn and envy”, before any scientific or mental health expert’s opinion.

Mahdi, an Iraqi male, who had personal experience with poor mental health when it affected his sister, said to me:

She wasn't sleeping at night. My mum used to sleep next to her so that she would not get scared. So we read the Quran to her, Roqyah, and she still gets terrified for no reason. She saw a sheikh for three days. He said there were things coming out from her eye, like energy. On the second day he talked with the jinn in her, he said, "I will be talking with you and reading the Quran."

While Mahdi was elaborating on his story, I was noticing how anxiety and panic were understood and therefore treated as a jinn possessing his sister's body. Some scholars (Al-Darmaki, Thomas, & Yaaqeib, 2016; Al-Habeeb, A, 2002; Al-Krenawi & Graham, 2000b; Han & Pong, 2015) argue that in Islamic belief, supernatural creatures like Jinn and demons can cause possession or change the behaviour of humans. It is noted in these studies that direct Qur'anic references to such things do not exist. However, I agree that many Arabic speakers who are Muslims or Christians will view the psychotic symptoms related to Jinn; Lim et al., (2014) confirms "hallucinations or other psychotic symptoms may attribute these experiences to jinn" (p. 18). Dein & Illaiee (2013) also state that possession by demons or evil spirits is one of the oldest ways of understanding physical and mental illness. Hence, "Almss لأمس (Demonic Possession) is widely believed by many of the community members, especially Muslims. The oral lore within Sunni Muslim groups confirms that the Quran does not mention physical possession by Jinn, according to the Grand Mufti of the two Islamic holy mosques Ibn Baz⁶, and it is a fact that many interpretations of the Quran remain highly contested and culturally volatile.

Whether or not it is simply oral lore, many of the research participants believed it might be jinn and not psychotic mental illness.

⁶ Abdul Aziz ibn Abdullah ibn Baz (Arabic: ) was a Saudi Arabian Islamic scholar. He was the Grand Mufti of the two Islamic holy mosques.

But relating to the research participants views, I could not help but reflect on how demon possession in a human host body isn't mentioned in the Quran or Sunnah. I have studied the Qur'an and Sunnah for 15 years in formal education; and the only mention in the Quran of the existence of jinn is as follows: “.. and there were men from mankind who sought refuge in men from the jinn” (verse 72:6).

This verse refers to men who were seeking refuge or shelter with demons, but there is no evidence that Jinn could actually possess human beings. From my own experience as a Muslim practitioner and as part of the community while growing up, I did hear many folklore stories about Jinn, but none of them appears in the Qur'an.

In Arabic folklore, it is believed that Jinn can haunt or possess a human being, causing illness, hallucinations or aggression. Such possession is believed to be caused by harming a Jinn (even unintentionally) summoning them or when a Jinn falls in love with a human, wanting to become his/her husband/wife. As a result, it requires an exorcism to dismiss the Jinn.

I learnt about this from the story of “*Abo Qureena* أَبوقريّنه”, a famous historical folk story about the cultural beliefs and practices as an influencing factor for the “health of the mind”. I found an unintended bridge forming between me as a researcher and the community around the shared stories, and the cultural beliefs and practices that people grew up with. It is well known in Western Saudi Arabia, Hijaz my homeland. “*Abo Qureena* أَبوقريّنه” is considered with a specific lens in the Saudi community, given that 78% of my research participants were from Saudi Arabia. In the Middle Eastern mythology “Abo” means ‘father of’ and the Qareen “Male” and Qareenah “female” (قريّنه) (Arabic: قارئن qarīn) meaning: ‘constant companion but the “ah” at the end of it for a female. It is a spiritual double of human, either part of the human himself or a complementary creature in a parallel dimension. Due to its ghostly nature, the Qareen is classified among the Jinn-type creatures, although not actually a Jinni.

The concept of a Qareen appears in pre-Islamic literature as well and is related to the Greek demons and the Christian guardian angel. Furthermore, it has its origins in the ancient Egyptian religion and beliefs, which is pre-Islamic Arabia (El-Shamy, 1995). The Qareen is invisible, but a person with “sixth sense” can see them, often in the form of a cat, dog, or other pets. According to the folklore tales, certain people can be possessed, which is now referred to as “Jinn”, and they cannot marry or the Qareen, which is a form of “Jinn”, will harm them.

My father used to tell me the story of “*Abo Qureena* أبو قريانة”, one of the horror stories that, as a child, made me think a lot about the moral behind it, besides scaring me. “*Abo Qureena* أبو قريانة” was a young man roaming the old town of “Sharafiah” in Jeddah. He looked like a skeleton and would stand up in front of the local traditional tea house “Qahwa” just staring at patrons aimlessly, and when people invited him to share the food, he would roll his eyes at them and walk away. “*Abo Qureena* أبو قريانة” was mysterious and somehow scary. People would rather not have any contact with him as he was dirty with ragged clothes and scars all over his legs, feet and head. People said that he was a curse and his look could curse you. When children asked their mothers about “*Abo Qureena* أبو قريانة”, the mother would respond that “a female Jinn is living in his body” and warned children to stay away from him while reciting “Almouthat”.

I heard this story from my father when I was young, but it a “given” that I was not sure what the moral behind is. Growing up in a modern city of Jeddah with no person wandering in the streets, I started doing research on this folk story.

My father said he saw “*Abo Qureena* أبو قريانة” a few times aimlessly wandering, and one time he was staggering, then he fell on the floor, he would shake, and people said, “the *Qureena*” is angry.

Then, someone brought a knife, draw a circle around his body on the dirt floor, then planting its blade above his head. Locals would start reading the “Muathat”.

After a while, looking at this, I remember what my father said, “they all told me the knife was shaking” but I did not see it. I saw a really disturbed sick man. While these old storied blinded people into believing things”, that statement has been part of my belief system. I realised how some stories we hear as children, builds up our knowledge, beliefs and stays in our memories.

This has made me reluctant to believe folk stories and the supposed meaning they hold when it is about people with mental health issues. As I explained in Chapter 5, the concepts we build do form our beliefs and the way we understand things. I believe the cultural perspectives that seem to be embedded in the community through folk stories have had a role in the way people perceive and deal with mental health.

Another sort of jinn is possession by Satan (identified with Iblis إبليس) which, according to Islam, can incite humans and Jinn to do evil. Two of the participants mentioned this; one is Omnia, a Bahraini-Saudi female, the other Mons, a female Saudi mental health nurse, who said:

“When people –Arabic speakers-see someone who has a mental health issue they relating it to possession and Jinn, and that is because they are not religious, because of that its easier for jinn to possess and to control him.”

It is stated by in Saheeh Muslim – as the main reference for Sunni Muslims- that *Iblis* or Satan and his subordinate demons whisper to the hearts of humans with free will, trying to lead them away from God and their spiritual commitment to religion or hunts them to fight against each other. But *Iblis* or Satan does not possess humans physically. It is noteworthy that when I revisited the book of Sunnah, it is stated that if a person feels depressed or feels trapped in a doubtful situation, Satan could abuse this situation and will whisper to the lonely heart. This

shows the depth of cultural and religious beliefs related to mental health, and how the cultural interpretation, understandings and concept, built the research participants beliefs on mental health issues.

6.2.2 Sihr & Rabet سحر وربط Black magic and spells (sorcery)

Another explanation that I came across when I asked the participants, including Yousef, who is a Saudi male, and Rogaya, a Saudi-Egyptian female, about their views of mental health issues, or how the community perceives them. The word magic, i.e., sorcery and spells, was mentioned 200 times throughout the 20 interviews. It was also mentioned as a response in the survey. I will first explain what the Arabic meaning behind it is, from my own experience of being part of the community, and then present the empirical findings of Sihr & Rabet: Black magic and spells (sorcery) as one of the factors contributing to the ways people view mental health issues.

It is noted in the Western literature that magic is linked to illusion and the psychology of perception (Vyse, 2013). Hence, as I mentioned in Chapter 5, people form concepts through beliefs (Sterelny, 1990), and for Arabic-speakers, especially Muslims, magic is part of their belief system. One of the participants said:

Most people link it to social conditions, like black magic. (Yousef)

Three other participants expressed similar views. Mona, a Saudi female and a mental health nurse, Sana, a Saudi female, and Mahdi, an Iraqi male, believe these views are linked to oral knowledge through elders sharing these stories, but they would talk about it with fear and sorrow. However, “*Rabbet ربط*” has two concepts; one is the spell or the witchcraft that is performed to control the husband or wife to either stay loyal or to disrupt and break their relationship. The other is culturally a sort of sorcery or black magic thought to affect their

thinking and emotions in the middle of sexual arousal through the use of a “voodoo doll”, as seen in Figure 6.



Figure 6. An example of “Rabbet رَّبَط” found in Saudi Arabia

This photo is an example of “Rabbet رَّبَط” found deep in the ground in Wadi Aldawaser in Saudi Arabia and was reported on the Saudi news. My great aunt said “If a man approaches his wife for intercourse, Satan disrupts sexual arousal in the brain emotion and body” which I believe may result in disturbing reproduction and fertility. I found relevant information in an Arabic book called “Alam Alsihr” by the renowned Muslim scholar Alqarni, A, that confirms the role “Rabbet رَّبَط” and how it looks like.

Let me elaborate on that from the story Rogayh shared with me about her father, who has been diagnosed with mental health issues. She told me:

In the beginning, nobody knew until it really affected his job, and he wasn't able to go to work, then it was noticeable. Then, his mum knew that he is ill, and so her way to

treat that “illness” is to get him a Sheikh for healing because he is actually possessed by Jinn, or that someone has done Sihr for him or my mum did that, so she can control him, and I know, he was actually being controlled by depression, not by something else.

So I asked, “What you mean is that his mother, your grandmother, was saying that your mum is the one who did the “Rabet”? She replied:

Yes, that my mother, she put a spell on him, “Rabbet”, controlled him so that she can lock him in the house and she will have control over him. He was depressed and did not leave the house because of that, and he is not able to go out. I don’t believe it was “Rabet”. But of course, there is some benefit with religious readings healing, and to treat magic by magic according to my grandmother, they say there is white and black magic, the black magic to cause harm to someone, the white magic is to disassociate and lift that. This has affected people’s views about mental health. And so interferes with their thinking”.

So, I asked “But tell me, how do they link these things? What is their main goal?” She answered:

The goal is to control a specific someone. As an example, they take a hair as a link to the person who has envy or who is considered as a victim. Or they might take clothing and pictures, and they perform some weird actions on it, and then they throw it to a difficult place in order to keep the effect protect from disturbing. (Roquayah)

Roquaya’s story noted a similar view that was represented in one of the survey questions particularly focused on the role of cultural beliefs in mental health-related issues. But let me highlight what the Qura’an say about Sihr & Rabet سحر و بيط Black magic and spells (sorcery) given that is the holy book that most of the research participants follow being Muslims

In *Surat AlBaqarah*, the second chapter of the Quran, it is stated:

[illegible]

(101) And when a messenger from Allah came to them confirming that which was with them, a party of those who had been given the Scripture threw the Scripture of Allah behind their backs as if they did not know [what it contained]. (102) And they followed [instead] what the devils had recited during the reign of Solomon. It was not Solomon who disbelieved, but the devils disbelieved, teaching people magic and that which was revealed to the two angels at Babylon, Harut and Marut. But the two angels do not teach anyone unless they say, “We are a trial, so do not disbelieve [by practising magic].” And [yet] they learn from them that by which they cause separation between a man and his wife. But they do not harm anyone through it except by permission of Allah. And the people learn what harms them and does not benefit them. But the Children of Israel certainly knew that whoever purchased the magic would not have in the Hereafter any share. And wretched is that for which they sold themselves, if they only knew”. (Quran 2:102)

And in *Alfalag*:

And from the evil of those who practise witchcraft when they blow in the knots (al-Falaq 113:4)

The Quran mentions that magic exists and humans were taught about magic at a certain stage, but they abused it, and the Quran condemns whoever practices magic. However, I am only focusing on unpacking these beliefs and linking them to mental health which is mistaken by

Sihr & Rabat سحر و بطل Black magic and spells (sorcery) according to some of the participants, and not looking at the accuracy or existence of magic.

Nevertheless, the online survey participants did not relate to the views expressed by the interview participants, as when I suggested Sihr & Rabat سحر و بطل as a reason for a mental health condition, less than 2% agreed.

Figure 7 was adopted from the national mental health survey mentioned in Chapter 4:

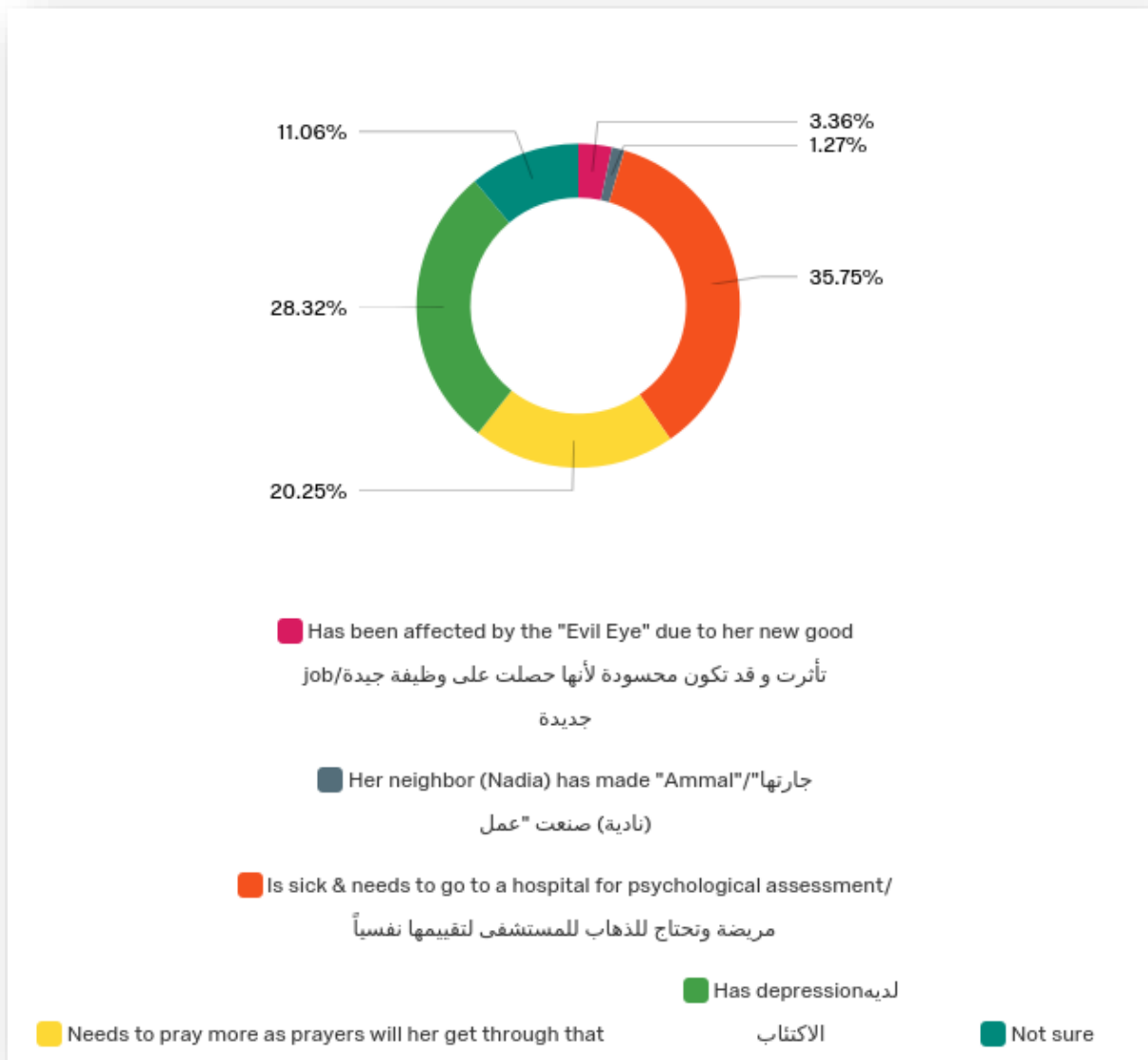


Figure 7. The results of survey questions particularly focused on the role of cultural beliefs

The participants had different responses that explain the cultural beliefs behind their thinking; 40% indicated it was “Hassad سحر due to her new good job, “Ammal” or she needs to pray more as prayers will get her through that. The other 60% feel that Fatmah has depression and needs to go to a hospital for a psychological assessment. Although most of the participants were living in Australia, it seems like many of them still believed Sihr & Rabat سحر و رباط Black magic and spells (sorcery) and other cultural and religious beliefs are the cause of her distress, and

the reason for her symptoms, which are typical symptoms of depression according to the DSM-5. I will talk about other factors in the upcoming sections.

6.2.3 Hassad حسد & Al-ayn لعين (Envy and Evil eye)

“Hassad حسد” & “Al-ayn لعين” are believed to be contributing factors to mental illness, instead of having a scientific outlook that explains symptoms like isolation, sadness or fatigue in terms of the DSM-5. Some of the people I interviewed said it could be “Hassad حسد” & “Al-ayn لعين”. Islamic scholars like Hekmat (2013) define “Hassad حسد” as the wish and a desire for the disappearance of grace and good from another human. It should be noted that “Hassad حسد” envy is more general than “Al-ayn لعين” the Evil eye. The first is the feeling associated with this “evil act” while the other is the “move” or the action in which a person is intended to harm another person, which is explained traditionally as those who look with (Al-ayn) Evil eye are (Hassad حسد) envious (Hekmat, 2013).

There are many cultural interpretations of what seems like depression and/or anxiety among the Arabic community. I have realised there are many similarities between the signs and symptoms of the “Hassad حسد” & “Al-ayn لعين” and the symptoms of mental health issues as categorised in the DSM-5. Table 3 is a comparison between the signs and symptoms of “Hassad حسد” & “Al-ayn لعين”, mental health issues that I have personally encountered while working as a practitioner, and what the participants provided. It is noteworthy that there is a lack of English literature that studies signs and symptoms of the “Hassad حسد” & “Al-ayn لعين”. However, some studies have referred to them as a concept that is represented in other cultures (Haque, 2004; Krawietz, 2002; Stein, 2000). I also reviewed the Arabic literature in (Hekmat, 2013) as the main encyclopaedia for the Islamic views on “Hassad حسد” & “Al-ayn لعين”.

Table 3 compares the recognised signs and symptoms of mental health issues like depression and anxiety with the signs and symptoms of “Hassad حسد”, which are derived from what some

of the participants understand and explain to be the signs and symptoms, what I have experienced within the Arabic community and what is provided in the valuable Arabic literature and resources⁷. This explanation will contribute to understanding, the way Arabic speakers may understand some typical symptoms of mental health as “Hassad حسد” & “Al-ayn العين”.

⁷ The resources were collected from a field trip to the Middle East that included Dubai, Bahrain, Egypt and Saudi Arabia. Some of these books are rare.

Table 3. The comparison between the religious/cultural concepts of Hassad and Al-ayn in Arabic literature and culture, and the diagnostic criteria for depression and anxiety in the DSM-5

DSM-5	“Hassad حَسَد” & “Al-ayn لَعْن”
<p>The diagnostic criteria for Depression:</p> <ul style="list-style-type: none"> • Depressed mood most of the day, nearly every day. • Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day. • Significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day. • A slowing down of thought and a reduction of physical movement (observable by others, not merely subjective feelings of restlessness or being slowed down). • Fatigue or loss of energy nearly every day. • Feelings of worthlessness or excessive or inappropriate guilt nearly every day. • Diminished ability to think or concentrate, or indecisiveness, nearly every day. • Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide. 	<ul style="list-style-type: none"> • Constant yawning. • Crying for no reason • Face becoming pale • Loss of appetite and there is no medical reason behind it. • Losing weight • Isolation and disliking people, or being in social gatherings. • Not having an appetite for food • Fatigue or loss of energy • Lethargy • Laziness and procrastination. • Constant anger. And this is one of the biggest signs of the “Hassad حَسَد”. • Having suicidal thoughts. You become extremely depressed whilst you were totally fine before. • Problems with sleep • “Hassad حَسَد made you depressed. And Shaytan wants you to despair, and no one despairs from the mercy of Allah except those who disbelieve in Him. • Constant headaches on one side of the head.

<p>The diagnostic criteria for Generalized Anxiety Disorder</p> <ul style="list-style-type: none"> • Too much anxiety or worry over more than six months. This is present most of the time in regard to many activities. • Inability to manage these symptoms • Restlessness • Tires easily • Problems concentrating • Irritability • Muscle tension. • Problems with sleep • Muscles pains • Headaches • Stomach aches (cramps, nausea or vomiting) 	<ul style="list-style-type: none"> • Constant anger and Irritability • Constant dizziness, Constant vomiting, especially during Ruqya, Constant shaking/shivering During ruqyah, you start to sweat, yawn, tears come out of the eyes, have diarrhoea. These are all good signs of curing the “Hassad حسد”. • Restlessness • Problems with sleep • Worry and fear with no apparent reason • Constant headaches on one side of the head. • Fearing that you will die and get a terminal illness. You are constantly shaking and saying: “I am going to die.” • Sudden onset of many sicknesses. Muscles pains, Headaches, Stomach aches (cramps, nausea or vomiting)
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This comparison contributes to understanding the way some Arabic speakers may understand typical clinical symptoms of mental health as “Hassad حسد” & “Al-ayn عين”.

One of the participants who has experienced this is Yousef, a Saudi male, who talked about his experience with his wife:

My wife experiences this strange mental condition. I don't know, it could be “Hassad حسد” envy, it's possible. I can't figure it out. She is not aware about her condition, because she can't see it when she is in the middle of it, the episode, and she is not

thinking clearly, I can say that my wife's condition could be closer to some physical issue, that is related to the mind, mental illness.

Yousef linked his wife's condition to "Hassad" although he mentions mental and physical illness. However, from the rest of the interview, it was apparent that his wife is suffering severe panic attacks due to an anxiety disorder.

Key points are only unravelled through long stories and narratives – and for this research, I have chosen to include a few of them to illustrate the point. ~~I was not surprised~~ as I found that many of the participants- even when they know the condition, they still fall into the cultural pattern in referring mental health issues to Hassad. It is noted that "many Muslims also believe in *hasad* (envy, or the Hassad حسد) as a cause of illness and misfortune because it is mentioned as a source of ill health in the Quran" (Inhorn & Serour, 2011, p. 941).

An experience I had myself when I was 15 years old in high school, which was a girls-only school in Jeddah, Saudi, we had a quiet girl "Doha" who was so isolated and scared most of the time. She was the first in the class and always had full marks. Doha was extremely thin; you could see her cheekbones, and collarbones coming through her white-collar school shirt. She suddenly stopped coming to school, and after a week, her mother came to the school; and during the second class of the day, the door opened, and the principal said in a series tone:

Girls, you are required to wash off/ Ablution – wudu وضوء in the "tashet" (bucket) outside. Your classmate, Doha, stopped eating and drinking, and we believe it's "Hassad حسد"

At that time, I did not know what was wrong with Doha. I actually felt sorry for her and rolled up my sleeve for Ablution "the Wudu". But reflecting back, I could see that she had a severe anxiety disorder and a possible case of anorexia nervosa or other eating disorder. However, the cultural perception had made her family deal with it as Hassad, knowing nothing at that time

about mental health issues. Most of what we learnt at school was direct verses of the Qur'an, and the interpretation of these verses was subject to many factors such as study curriculum and the teacher's Islamic views.

The Qur'an mentions "Hassad" in a few places, including the following verse:

From the evils of the envious when they envy. [Quran 113:5]

This verse says that there are envious people who have evil eyes. Although this verse confirms that some people have evil (eyes) when they are envious (you can be blind but have that envious feeling), many Muslims believe God who permits anything to happen to people as it is noted:

Nothing happens to you except in accordance with God's will. Anyone who believes in God, He will guide his heart. God is fully aware of all things. [Quran 64:11]

The research participants also mentioned it as a societal pressure.

The society forces it, the society with its customs and traditions has forced among us all a certain pattern of believing that it is "Hassad . حسد" (Rania).

Other participants of ~~my~~ research also mentioned that people's belief in "Hassad حسد" discourages them from pursuing any treatment for mental health.

They don't believe it something related to Mental health. Their view is that they are having a "Hassad حسد" and you are envied. (Monirah)

Such cultural belief has a major impact on the health and well-being of the community and indeed on the mental health literacy. Another participant adds:

He was depressed and locking himself up in his room, his family light up incense and used traditional herbal remedies to take out magic and "Hassad حسد", they will do everything to take out that "Hassad حسد" and it affects people, they would also bring a Sheikh to read on him. (Amenah)

As Amenah, who is a Saudi female, mentioned when the community has firm cultural beliefs about the cause of mental health-related symptoms, they will seek alternative healing processes that I will discuss in detail in Section 6.3.

However, as mentioned in Chapter 5, more young, educated participants have started to view the way mental health challenges should be treated differently.

I think it's a culture thing that was passed down by society. I feel that new generations don't believe these things anymore. They consider it to be old and not true, I mean, for example, if my sister is having mental health issues, and I tell her to go and see the sheik she will say, "Are you serious?" She sees it as something old and unauthentic. Just like I told you, we are a conservative Muslim society that is being dominated by a religious system, and since a long time ago, mental illness has been classified as "Hassad حَسَد" envy, which needs religious reading and healing. And this will take that patient away from professional treatments, and so it has highly affected their understanding [about mental health]. (Mishal)

The views shared by the research participants are Islamic and cultural viewpoints on mental health while relating it to the Quran. Within the Quran, segments are referenced to a holistic model healing. This model depends on the interrelation between the *ruh* (soul), the *qalb* (association between the spirit and the body), the *aql* (judgment) and the *nafs* (drives or wants) converging through the *dahmeer* (consciousness). As a result, the Arabic-speaking community may recognise profound sicknesses, as indicated by some of the participants, as "Hassad حَسَد" & "Al-ayn اَلْاَيْن" and not necessarily a diagnosed mental health issue.

6.3 Cultural beliefs and practices

Cultural and religious factors play an important role in people's perception and knowledge about mental health literacy. Stigma is one crucial factor that many studies have shown to

explain the low service accesses to mental health services (Al-Krenawi, 2002; Al-Krenawi et al., 2009; Aloud & Rathur, 2009; Haj-Yahia, 1995; Jorm, 2012). The main themes that were documented through the analysis, and I have noted while working with the community were mainly Ayeb عيب (Stigma and shame عيب) and Manhood.

6.3.1 Ayeb عيب (Stigma and shame)

Stigma is one of the most influencing factors affecting mental health literacy (Jorm et al., 1997). The definition of stigma that I found in a report published by the Department of Health in Western Australia describes stigma in the same way as it is being interpreted in this research: “Stigma is a mark of disgrace that sets a person apart from others. When a person is labelled by their illness, they are no longer seen as an individual but as part of a stereotyped group. Negative attitudes and beliefs toward this group create prejudice, which leads to negative actions and discrimination”. Internationally, stigma is well-known as a barrier to dealing with mental health challenges. “The single most important barrier to overcome in the community is the stigma and associated discrimination towards persons suffering from mental and behavioural disorders” (WHO, 2018).

Aligned with these definitions, in one of the interviews Asmah, a 32 years old female from Saudi, highlighted that:

People in the Arabic community are afraid to be labelled by their mental health issue. There is no acceptance. My sister, she said that her child is always angry with a bad mood, so, she pushes everyone away as she is afraid of “Aybe”. It even reaches a point where she will isolate herself from the community and wants her daughter to get out [of home] and doesn't want anyone to hear that her daughter has a mental health issue.

This shows how people not only avoid seeking help but also avoid community contact, which impacts their mental health issues even more.

Stigmatising attitudes have been assessed in some studies, such as Reavley and Jorm's (2011c) National Mental Health Survey, which assessed personal attitudes towards varying types of mental illness, stigmatising attitudes and participants' beliefs about others. The results revealed that "stigmatising attitudes towards those with depression, schizophrenia and anxiety disorders differ according to [the] disorder, with differences between schizophrenia and social phobia being particularly striking" Reavley and Jorm's (2011c, p. 1092).

However, the NMHS, although very important, did not include any non-English speakers, as the sample was contacted by random-digit dialling of both landlines and mobile phones in Australia, and targeted English speakers. Stigma is a similar concept in almost all cultures, but for Arabic speakers, it is felt even more deeply. Stigma has an even greater impact on people of colour and ethnic cultures, and some studies confirm that the lived experiences of mental health stigma may be an extra burden for those from racial and ethnic groups (Ahmedani, 2011). The concept of double stigma arises from prejudice and discrimination occasioned by an individual's racial identity besides their mental state (Ciftci, Jones, & Corrigan, 2013).

Generally speaking, there are two types of stigma: self-stigma and public stigma. The first is the stigmatising attitude that a person holds toward themselves if they have a mental health issue; a sense of shame and a belief that they should not be weak but should-be able to "snap out of it". The second, public stigma, is how the community reacts to people with mental health issues. Stigma "diminishes self-esteem and robs people of social opportunities" (Corrigan et al, 2004, p. 614). People with mental health issues in the Arabic-speaking community and their families do experience significant levels of stigma and discrimination (Al-Krenawi & Graham, 2000). The most common form of stigma in the Arabic-speaking community is that a person who is unable to cope with mental health issues or distress is displaying weakness, not an actual illness. This was confirmed by *Alya*, a Saudi-Yamani female, who stated that:

They should not be weak, and be able to snap out of it!

Few other participants agree with Alya. However, through working as a practitioner among the Arabic-speaking community and while analysing the interviews, I have come across the fact that people keep mental health challenges a secret because they are ashamed of it and they would not want to be seen as weak. They will be reluctant to disclose a diagnosis, due to concerns about stigma, shame and “Ayeb عيب”. As a practitioner, I saw many clients showing a desire for social distance. A few of them mentioned to me they might even lose their friends because their friends were so judgmental, or did not understand their condition or suffering. Moreover, temporary migrants or residents may even be sent back to their country of origin, as Australia, for example, does not want to carry the cost of treatment

However, recent Beyond Blue research (Beyond Blue, 2018) indicates stigma -or “Aybe” as I refer to in this research- still a challenge in Australian communities regardless of their backgrounds, and the assumption that many Arabic speakers have – including myself until recently-. Their research concludes that stigma has a significant impact on people’s lives, personal relationships and employment. Aybe, stigma or shame, are all factors that were mentioned repeatedly though out the interviews and the survey, but I could related to what Mehraby (2009) mentioned about its significance in the Arabic-speaking community; she states “Social reputation is of significant value in Arabic culture and enormous efforts are made to avoid any shame that may endanger the family reputation. Arabic families show strong preference to provide support for family members when needed, including suffers of mental illness. Families can act as a protective shield against stress, but can also be a source of stress if an individual deviates from their collective values. Help-seeking is perceived as a ‘collective enterprise’ and individual sickness is considered a family business” (p 43).

This was confirmed by one of the participants who shared her story with me, about “Ayeb عيب” and the impact of it on her life. Her story is an example of and relevant to the point discussed previously, and supports other studies that state that shame may endanger the family reputation

in the Arabic-speaking community (Ahmedani, 2011). Jamilah, a 35 years old mother who considers herself an Arab-Australian with an Iraqi culture, gave an insight into her personal experience, which has been reproduced here in full as I believe sharing her full story is important. She said:

They are not looked at as having a mental health issue. They promote it as he is crazy, so he is less a human being in a way. There is not much empathy around mental issues, they're not looking in an empathetic way. It's almost an embarrassing thing, a stigma attached to it. So, for example my son, actually when he was around five he was diagnosed ADHD. His dad and myself made a decision not to tell his family, due to the Arabian culture, and the reason for that was because we know there is "Ayeab عيب" and stigma attached to it. He will be perceived differently and perhaps be treated differently, but he wouldn't be perceived as a normal child, like everybody else. He would be perceived as being crazy and, how do you say it, like written off, discounted. So we were happy, we thought it was better to let them think that he was misbehaving because he was an odd boy and he wasn't raised well, and we were not parenting him in the right way. We should rather that than let them know that he actually has a medical, mental diagnosis and he has you know, ADHD. We decided that that's what we gonna do because if we had announced it or let them know of that, it wouldn't have been okay. Not only would it not be okay for us to talk about enabling him as being different, enabling him in a negative way, it wouldn't be even okay for the children to accept him as he was. He could be easily picked-on or teased or things like that. And also if any issues were to come up with kids together or having problems with one another, we could almost guarantee that the response from the parents of the other children in the family would be, "Ohh, he is like that, he is crazy. He is crazy, don't worry about it, Just forget about him, leave him, he is crazy" and make these common gestures and

things like that, so we thought we are making the right decision by doing that. The rest will believe that till this day, so like, for example, my son takes medication when he goes to school to regulate his behaviour for his ADHD, so he is not so impatient, so he can concentrate on his work, and that calms him down. We don't give him medication on the weekends because of the side effects, but recently I decided whenever it's time to visit my husband's family and cousins on the weekend, I make my son take his medication because I want his behaviour to be regulated in front of them, so that he can be perceived as normal. This is because I know that there is strong stigma attached to anything that is different, and how he would be perceived by them. So that's probably an example of the cultural perception. It's not something people empathise with, it's not something that people are aware of, and it's a quick assumption that if a person doesn't function in a way that is culturally acceptable, or follow the cultural norms of behaving, that they could be labelled as being crazy. It's just black and white to them, but there is a lot of grey area in between so, yeah, that was one thing. Mental illness is not categorised to them and it is just put into one basket, without differentiating the level of sanity. (Jamilah)

Her story about her son's ADHD challenge reveal the way both types of stigma could impact the well-being of a family.

Other participants like *Yousef* also emphasised on the fact that stigma and the fear of community's perception (both in the presents and the future) exists.

Yes, because they don't want to hear a word that will hurt them because you know in Saudi Arabia these things are distributed and it sticks with the person even at the future, they will say this guy is having...etc." (Yousef)

The type of stigma that considers the public perception has implications for both practitioners and the legal system. This is because people may not speak up as the fear of societal judgement exists.

I always recall a word that comes to my mind in Arabic language when thinking about people with mental health issues is called *Ie'aqa* إعاقة (mentally impaired) and I believe it creates a stigma. In Australia, they are called people with special needs. Recently, in the middle-eastern societies, this is changing to “people with special needs”. One the participant confirms:

I think it's not just a societal level in terms of people and the community a, it actually starts with government and high levels as well, because they're pushing down these perceptions on to people so that's something that maybe needs to be looked. “ It's is very important to talk about Arab people who they may think about mental health issues, I think the fear comes from the religious point of view, they're afraid from having any record, that this person is suffering from any types of a mental problem. (Ali, Saudi M)

Ali concludes the issue of stigma as both the responsibility of individuals and communities and also a government responsibility in changing the discourse for people the mental health issues to tackle the stigma.

As the findings demonstrate, “*Ayeb* عيب” stigma and discrimination can have a significant impact on people with mental health issues and their family and friends. It also impacts their personal relationships and employment. Previous research also argues that friends will avoid a person with mental health issues and employers may not hire them (Szeto & Dobson, 2010)

Mental health services can be stigmatising, particularly for women. Ethnic Arab clients, like those in other non-Western societies, find psychiatric and psychological intervention (Fabreka, 1991) and family and marital therapies stigmatising (Savaya, 1998). This is especially relevant

for women. The stigma of mental health services could damage their marital prospects and increase the likelihood of separation or divorce especially among Muslims, be used by a husband or his family as leverage for obtaining a second wife (Al-Krenawi, 2014). *Roqiayah a Saudi-Egyptian* mentioned the stigma about the mental health challenges her father had and its perceived impact on her marriage in the future.

...it does have Stigma, people consider it as something shameful. For instance, one of the things that my mom told me is that “ don’t tell anyone that your dad is tired because no one will marry a girl her father is crazy. (Roqiayah)

Stigma may be avoided or reduced by integrating mental health services into non- stigmatising frameworks or physical settings, such as general medical clinics (Al-Krenawi & Graham, 2000a). However, I will talk more about best practises and intervention to tackle what I have found about this contributing factor to mental health literacy, in Chapter 7.

6.3.2 رجولة (Manhood)

Many studies highlighted that gender considerations exist when looking at mental health perceptions and acceptance (Astbury, 2001). The National Survey of Mental Health (NSMH) states that a high prevalence of mental health issues exists, which leads to an alarming number of suicide attempts. According to the ABS (2016): “In Australia, suicide is the leading cause of death for males and females aged between 15 and 44. In a typical year, about 3,000 people in Australia die by suicide. That’s an average of 8 people every day”. In Western communities where mental health issues are easily discussed, men still do not talk about it openly and seek other alternatives like drinking to deal with it. This leads to a high number of suicides among men. According to Beyond Blue: “Blokes make up an average six out of every eight suicides every single day in Australia”, as they state on their website. The number of men who die by suicide in Australia every year is nearly double the national road toll. As much as this painful

fact has shocked me, I could not help but wonder about the deep meaning between Arabs about manhood, and how this is one important factor for people to have mental health literacy. It is obvious that this is closely related to stigma, but I aimed to highlight stigma from the eyes of my participants given their stories are usually hard to get out.

The same pattern of gender considerations exists in different Arab community. The cultural images of Arab men's masculinity and power have embedded deep down within the community and handed down through generations. This image forces men to be emotionally strong, regardless of any existing mental health diagnoses. ;

Gender implications within the Arabic-speaking community tend to remain strong, given the cultural norm with male dominate communities as Al-Krenawi (2014) assert "the social structure is male dominant." (p.61). Unfortunately, women are culturally still perceived as "physically and mentally weak in comparison to men" (Attir, 1985, p. 121). I grew up in one of the most controversial countries in the world, Saudi Arabia, that has been represented repeatedly in the media and through the cultural norm for men to be the leader and to have the highest authority in the family or the work environment. In many Arab societies, women's social status is strongly dependant on being married and raising children, especially boys, to increase the status of the family. In my community, men are the main carers for the family, and they are expected to be providers, especially Muslim men. This is even mentioned in the Islamic teachings and is clearly stated in the Qur'an:

Men are in charge of women by [right of] what Allah has given one over the other and what they spend [for maintenance] from their wealth. (4:34 Al-Nisa سورة النساء)

لَرَجَالُ الْقَوَامُونَ عَلَى النِّسَاءِ بِمَا فَضَّلَ اللَّهُ بَيْنَهُمَا وَمَا يَرْزُقُونَ مِنْ أَمْوَالِهِمْ

This ideology around manhood (رجولة Rejal) and patriarchy was also the norm in Western societies until the second-wave feminist movement started in the 1960s (Burkett, 1998).

However, in many non-Western communities, patriarchy is still the norm; even Western communities still experience some elements of patriarchy. As a woman who was raised in a patriarchal society in Saudi Arabia, I witnessed this ideology – manhood (Rejal • رجول) – again and again from a young age, despite the fact that my father raised me to be independent, feminist and liberal. The sense of entitlement that I witnessed, -along the years of being married- made me consider the burden it places on men and the stress that might be at play which is a leading cause to mental health issues (Reavley & Jorm, 2011b). But it is important to highlight that this consideration has helped me to ask the community some of the sensitive questions about manhood and its related stigma through the online survey and interviews. I interviewed six men, and the online survey indicated that 30% of the participants were men. I heard some compelling stories and narratives about manhood (Rejal • رجول). One of the questions asked in the survey was: *"What do you think the cultural image of a man who suffers from mental health issues is?"* ما هي نظرة المجتمع الثقافي للرجل الذي يعاني من مشاكل في الصحة العقلية؟ The responses are presented in Table 4.

Table 4. Online Survey: Responses to Question 14

HE IS PRETENDING, TO SEEK ATTENTION, OR AVOID RESPONSIBILITIES لأنه يتظاهر، أو يتجنب المسؤوليات، أو يتجنب الاهتمام	9.70%
CRAZY/مجنون	33.47%
DANGEROUS/خطير	23.48%
SOMEONE WHO IS WEAK AND STUPID (A SISSY) (هو رجل أضعف وغبية)	13.94%
HE IS IN NEED OF PROFESSIONAL HELP هو في حاجة إلى مساعدة طبية / نفسية	55.16%

Almost half of the survey participants did not believe that he is in need of a professional help but instead believed that the cultural image of a man who suffers from mental health issues is he is either crazy, dangerous, weak, a sissy “which in Arabic (هو رجل الشخص ضعيف وغبي)”; or he is pretending, to seek attention, or avoid responsibilities, given the cultural expectations from men, to be the man of house or the main provider for the family.

The stories and narratives about manhood (رجولة Rejal) relate to the consideration of men’s views toward mental health issues. From the interviews and living for the first 22 years of my life in Saudi Arabia that men are less likely to accept and acknowledge having a mental health issue because of the above-mentioned social factors.

Based on my observation of men from Arabic-speaking backgrounds and linking it with WHO (2001) statistics, it is noted that they are less affected by depression than women. Hence many of the participants drew on the cultural notion on women’s probability in sharing their feelings more than men. Furthermore, men are more affected by other mental health problems like substance misuses—for example; and they are more prone to take their own life by attempting or completing suicide, with six men on daily average in Australia according to a recent report released by Beyond Blue (Beyond Blue, 2018).

Migrants- including people from Arabic-speaking backgrounds- comprise between one-quarter to one-third of the Australian suicide toll, with newly arrived migrants particularly vulnerable (Morrell, Taylor, Slaytor, & Ford, 1999). Each year, on average, more than 600 successful suicide attempts were made by people born overseas (ABS, 2011). The last official count in 2014 revealed that the total number of suicides for the year reached nearly 3,000; people born overseas accounted for around 800 of these deaths.

Which brings me to understand, mental health issues, the leading cause for suicide, is hard to tack by many men, and the burden Arabic-speaking men carry is even double (Morrell et al., 1999) considering all the cultural factors I mentioned before.

These findings were also confirmed through my interviews from both male and female participants. Hamed, one of the male participants, spoke of the stigma attached to males seeking medical help:

Yeah, what is this weakness? What did you leave for women? It was getting more and more that no-one heard him and so he'd started to talk with himself during nightmares. And they get the idea that he could be tired, really tired in his psychology (mentally tired), and they think there is a condition in our family.

He was in a divorce case, and it was extreme. Its reality was a surprise for everybody, and one of the parties couldn't handle the fact that it was a reality, that (the marriage) was really over. So he reached a level of leaving his food, and people, and he stopped talking, and then he began to have hallucinations, I have seen him having that shock effect (hallucination), especially when he had it by the side of other men and there were saying, "Be a man, what's going on ? You're not the first or the last". (Hamed)

As Aseel, one of the participants, states below, even when men in our community feel a mental health issue themselves, they will not acknowledge it due to the cultural beliefs about manhood.

My husband is the type of guy who has pride. If he is ill, you find him with a physical illness, he will tell you, but if he is psychologically unwell, he won't say a thing. He will be minding his pride, but if he has abdominal pain, he will lay down showing pain, crying or complaining. If I ask him, are you sad or depressed, it's normal that he sees himself as Rejal "the man", and possibly thinks that these things should not make him depressed. For instance, a fight with his brothers, if you ask him, are you

depressed? He will say no, it's OK, and I know that in his heart there is something else, but he doesn't want to express the pain or sadness. He wants to be perfect in front of me. (Aseel)

Out of the 20 interviews, more than half of the participants shared similar views when it comes to men's perceptions of mental health issues and the culture of manhood and male masculinity in the Arabic community.

6.4 Cultural practises, traditional and religious healing practices

Cultural practises, besides traditional and religious healing practices, could be factors that contribute to mental health literacy; while at the same time they are conclusions for the communities' experience in reacting and responding to mental health issues. Hence, I will briefly touch on the most common cultural practices, traditional and religious healing practices that came across the interviews.

The previously analysed themes Jinn جن (Djinn), Seher & Rabtt سحر و ربط (Black magic and spells, sorcery), Hassad حسد & Al-ayn العين Envy and Evil eye have an important role as both contributing factors to mental health literacy and also as an "intervention". Eneborg (2013) describes these cultural, traditional and religious healing practices as:

... theoretically classifying types of spiritual illness; three familiar categories are evoked: al-ayn (the [evil] eye), sihr (sorcery) and mass (touched [by jinn]). These three categories of supernatural illness can all be supported from the primary sources of Islamic discourse (i.e., Quran and Hadith) and so are not contested by the majority of Muslims. However, their particular nature is much more open to opinion. (p. 1091).

Many Arabs do not acknowledge the existence of mental health, so they do not even consider seeking medical help from Western medical practitioners. As they believe mental health issues to be related to *sihr*, *jinn* and *hassad*, they seek interventions that are tied to their culture.

Two main themes came up when the research participant expressed their understanding of healing, Religious healing practices and cultural healing and practices

Religious healing has two aspects the first aspect is “Rogya Sharia رقية شرعية” which also called faith healing or Islamic healing that refers to reading verses of the Quran manly and using the “Sunnah” which are the teachings of Prophet Mohammad, which bring us to the second one “Qusl غُسل , Wudu وضوء” that translates to holy water washing cleansing, or oblation. The second aspect is: Cultural healing and practices, which refers to the way the participants view healing in the sense of what the community is practising that has no roots in the religion - particularly Islam- but I will elaborate on that in the upcoming section through examples.

6.4.1 Religious practices and healing

Religious healing is a critical factor in which mental health issues are perceived and dealt with, a consideration must be given to the role of religion in Arabic-speaking communities, regardless of whether Islamic, Druze, or Christian (Al-Krenawi & Graham, 1997). I came across the “Rogya Sharia رقية شرعية” and “Qusl غُسل , Wudu وضوء”. As a researcher, practitioner and part of the community, the participants confirmed my understanding for the research about importance of religious beliefs when dealing with mental health and the role of healing. King and Bushwick (1994) similarly confirms that “There is increasing evidence that attention to patients’ religious beliefs and experiences can enhance physical healing and a feeling of general well-being in patients” (King & Bushwick, 1994, Para 12). Yet, I was interested in how the participants’ current perceptions about healing and how they view religious healing. Many of the research participants shared similar views which support the importance of religious healing “Rogya Sharia رقية شرعية”

Mental health issues are not something people emphasise, nor something that people are aware of, and it's a quick assumption that if a person doesn't function in a way that

is culturally acceptable, they need to pray more, they need to be blessed with holy water, so water that's been blessed by the word of God or by Quranic verses. Or they need to visit the sheik or mosque, or they need to be guided by a religious leader. It's the norm to a human being suffering [from the Arabic-speaking community], to be in the company of the religious leaders more often. (Jamilah)

In Islamic teaching, the Quran states few verses around religious healing. The use of the Quranic verses for healing is familiar to most Muslims, and it is following the teachings passed down through generations and sourced through the “Sunnah”, which are Prophet Muhammad’s teachings; for example, reciting the Al-Faatihah (the opening chapter in the Quran) (Deuraseh & Tohar, 2008). The Prophet Mohammad said,

رُقْيَةٌ إِلَّا مِنْ عَيْنٍ أَوْ خُمَةٍ

There is no Ruqyah except to cure the evil eye and the sting.

According to Sunnah teachings, Ruqyah was used by the Prophet Mohammad, who said:

أَعِزُّكُمْ بِالْقَوْلِ إِنَّ اللَّهَ لَشَدِيدُ الْعِقَابِ مَنْ كُتِبَ عَلَيْهِ الشَّيْطَانُ وَهَامَهُ، وَمَنْ كُتِبَ عَلَيْهِ الْغَيْنُ هَامَهُ

Bismillahi arqeeka min kulli shayin yudheeka, min sharri kulli nafsin aw ‘aynin 159asid Allaahu yashfeek, bismillahi arqeeek.

In the name of Allah I perform ruqyah for you, from everything that is harming you, from the evil of every soul or envious eye may Allah heal you, in the name of Allah I perform ruqyah for you.

Ali, who is a 32-year-old male, talked about the above *Ruqyah* by saying:

The healers come to “Ruqyah” and read verses of the Quran, and that will actually be stopping people from acknowledging or seeking mental health issues help.

Cultural practises, traditional and religious healing practices could be counted as barriers to seeking help or knowledge about mental health issues. Seeking religious treatments from Sheikhs, who are not licenced, may cause damage to people who are severely affected by mental illness such as Bipolar disorder. Furthermore, religious healing is seen as a barrier to seeking support when it comes to Western mental health interventions. Western literature has argued for decades that religious healing should be based on scientific facts. Moreover, Western scientific perspectives on faith healing –or religious healing- view it as unexplained, without scientific evidence, incomprehensible, and useless. Yet, many cultures still believe it works. Flamm (2004) claims that “In the entire history of modern science, no claim of any type of supernatural phenomena has ever been replicated under strictly controlled conditions... faith in faith healing refers to an irrational belief, unsupported by evidence, that mysterious supernatural powers can eradicate disease. Science deals with evidence, not faith” (Para 36-37). It is noted that faith healing is similar to the placebo effect (Humphrey, 2002), through which a person may experience genuine improvement in their physical health. Hence, people affected by disturbance emotionally or physically will genuinely feel helped by the faith healer or cultural remedy, not through magic powers, but by the power of their faith in Allah and the cultural belief that they would be healed. This was expressed by some of the research participants, including Yousef, a 32-year-old male, who mentioned his personal experience with reading and explained:

My wife was mentally and physically ill. Quran with the prayers have helped her a lot, even when she was unconscious, she relaxed, and the symptoms disappeared. Sometimes I remember when she was admitted to the hospital and we brought a Sheik and he did “Rogya Sharia رُفِيَتْ شَرِيعَةً”. On the same day she got better and was discharged out of the hospital. (Yousef)

In some Western studies cultural and religious healing are grouped in one category and reduced to an acronym “TAFH” which stands for traditional and faith healing (Van der Watt et al., 2018). However, after analysing the data and considering the Islamic teachings that I received at a young age like many of the participants, religious healing is where religious text is used, or a practice that is backed up with actual verses of the Quran (Almobyd, 1999). On the other hand, practising other cultural renowned aspect like for example “*wudo وضوء*” where it is related to but not mentioned in a religious text, is traditional healing. However, the difference is highlighted here to elaborate the perceptions of mental health and healing from the eyes of the research participants. Many of the participants believed in the importance of religious healing.

For a condition like that [mental health], they will invite a Sheikh so he can do “Rogya” read because they are possessed by Jinn. Of course, we do have these beliefs. A lot of people believe it. (Asma)

Another participant added:

My cousin who was “Ta’abana” [mentally unwell], was treated with Quran or something spiritual, she committed to a schedule consisting of reading the first Chapter of Qura’an – Al-BAQARA –for a period of time until this thing became so much better. Some people said, the magic has been disassociated. Others said, a Sheikh has done that for her, and so it’s a puzzle. People don’t know exactly what happened to her spiritually, or which let her get better.” (Omnia)

It is widely known that with the concept of mental health in Western context, some studies exclude any sort of religious healing, but others agree, if it works, there is no harm in giving people hope for healing and recovery (King & Bushwick, 1994). Religious healing is being used in places like Australia, for example Christian sacred water and exorcism, although in

general Western medicine tends to translate mental health disorders with a clinical lens (Furnham & Hamid, 2014).

People who hold religious beliefs, and a stronger sense of God or a higher power, are more likely to overcome the disperse associated with many mental health issues (Al-Krenawi & Graham, 2000b). Lawrence, Oquendo, and Stanley (2016) agree, as in a systematic review about religion and suicides they mention that “Many studies indicate religious affiliation is protective against suicide attempts and suicide.” (p. 15)

As one participant sums it up:

But you don't dismiss the treatment because in the Quran, there was no procedure how to remove cancer, there is nothing in the Quran, but it says you have to do it وتلقوا فليس لكم الى انفسكم [do not throw yourselves to destruction]. You have to go and be treated, you don't say “I have cancer, I'll give up”. And one of the studies talks about religious healers, they found there is a connection between religious healers and people seeking help. If you need referring to a mental health service, if their mental literacy is high, a religious leader who knows about the symptoms, about depression, can read the Quran, read this this this, but I think you should go and seek a psychologist. (Ali)

The second religious practice for healing is “Qusl غُسل , Wudu وضوء”, which was mentioned in some Islamic text (Hadith) and is usually a statement prophet Mohammad said that is passed down through trusted scholars like “Muslim” “Albukahry” and others, for the purpose explaining and analysing. An example of “Qusl غُسل , Wudu وضوء” in Hadeeth:

عَنْ بَنِّ عَسَا ، عَنْ النَّبِيِّ صَلَّى اللَّهُ عَلَيْهِ وَسَلَّمَ قَالَ : (لِيُجْنَحَ ، وَلَوْ كَانَ شَيْءٌ عَسَبَقَ الْقَدَرِ سَقَّتَهُ لِيُجْنَحَ ، وَإِذَا لَمْ تُجْنَحْ فَتَغَابِغْ) (رواه مسلم)

The evil eye is real. If anything were to overtake the divine decree (and change it, then it would be the evil eye. And if you perform Gusl (to remove the evil eye) then wash

well. Muslim ibn al-Hajjaj (9th century), translation by Anas, Turki, & Sa'id al-Hadathani, (1994)

The traditional explanation by Ibn Baz (Baz & al-Aziz, n.d.) is to ask the person who has been impacted by the “Hassad نَحْسٌ”, evil eye on another Wudu to follow the Prophet instructed *Amir ibn Rabee'ah* -- his *sahaba* companions- to do in the hadeeth quoted above. The water should be used for *Gusl* and poured over the one who has been impacted.

It is noteworthy that Muslim ibn al-Hajjaj (9th century), was alone in recording the Sahih Muslim Hadith, as Al-Bukhari did not record it in his archival collections. This leads me to believe, as a Muslim researcher myself, it has a weak connection and proof and it could only be explained as the religious holy washing which I find a spiritual experience that symbolise cleansing. I do believe that this Hadith, if it was true, encourages Muslims to “cleanse” rather than using Wudu to remove an evil eye that could be merely depression or anxiety. Going back to these old texts and reading them in Arabic reminded me of the way I perceived “Hassad and Ayen”, that leads to even more questions than answers. Hence, if *Wudo* means cleansing, and a person would do it when they are anxious to help, it would not be an issue, but if it was a more complicated practice imposed on people around them with no justification, it could not help the person suffering the mental health issues. As a young girl, I heard our school principal in a serious tone

“girls, you are required to wash off/ Ablution – wudu وضوء in the blue *tashet* outside, your classmate Doha stopped eating and drinking, and we believe it's “Hassad نَحْسٌ”

At that time, I would have not known what was the case, I felt sorry for her and rolled up my sleeve for Ablution “the Wudu”. Some of the participants shared similar stories:

They wipe the “ A 'atba” [doortep for traces of comers] and then put that piece of cloth in water, then use it for Wudu. (Asma)

You take the water for that person and let him wash his hands, face, feet and some parts of his body and do Wudu, and then take that water and wash the person who is ill with it. What's the purpose of that? I don't know, I mean the prophet has said it, but I'm thinking about what could be the reason.” (Asma)

But even though this could be a factor contributing to mental health literacy, *Wudu* or other traditional healing methods, plays a role in the way people deal with mental health in the Arabic-speaking community, which I will be talking about in the next section.

6.4.2 Cultural practises and traditional healing

As I mentioned before, some Western views usually group these two different types of healing to one “TAFH” Van der Watt et al. (2018, p. 555). Cultural intervention and traditional healing in my experience is different to religious healing. I will be giving some examples shortly.

However, I was interested in my participants’ current perceptions about healing and how they used cultural interventions and traditional healing to deal with mental health issues. Even in Australia, which has a well-known western-oriented medical and scientific culture, many people still use such healing methods regardless of its Eastern origin. Some examples include Reiki, which is a form of alternative medicine (energy healing), or Naturopathy or naturopathic medicine, which is acupuncture, cupping or moxibustion (traditional Chinese medicine therapy that consists of burning dried mugwort off particular points on the body). Currently, many of these healing approaches are used in Australia to heal or treat physical and mental health conditions with certified and licensed therapists.

But healing – whether it is cultural or religious – is used in many communities worldwide as a successful non-Western approach, to help individuals with mental health issues. In the Middle East, culture plays a major role in healing when dealing with psychological struggles, and many healing processes such as “Ruqyah” have now been widely recognised and practised alongside

medical treatments (Thomas, Al-Qarni & Furber, 2015). Furthermore, in India, traditional healing and community resources such as temple healing rituals are widely used in managing mental issues according to Raguram, Venkateswaran, Ramakrishna and Weiss (2002), they give an example of a brief stay at one healing temple in South India, which they confirm in their study improves the persons mental health.

Other local traditional healing approaches are used for many years within indigenous Australians, in South Australia traditional healers are recognised in its Mental Health Act 2009(SA Health, 2019), which made a professional space for trusted members of the community healers to involve collaboration with health workers However, The *Anangu Ngangkari Tjutaku* Aboriginal Corporation (ANTAC), as the first organisation of Aboriginal traditional healers in Australia, have made a collaboration of traditional healing within the health system in Australia, and it is now possible for healers to visit hospitals and rural clinics as needed in Victoria, New South Wales, South Australia and Western Australia (Korff, 2019).

While looking at healing from different cultures, it brings me to the Arabic-speaking community and one of stories I heard from some of research participants, about the traditional healing of “Kayy كئي”; a technique that is similar to moxibustion but in the Arabic-speaking culture is using a metal iron to heal people, ~~it is something I also learnt growing up in Saudi Arabia as a traditional normal part of everyday life. However, I believe this upcoming story from a participant, will give the reader an example – a narrative of the way cultural and traditional healing influence people perception about mental health, and even their own mental health. Then I will bring another story, which analysis a less invasive practices, that I will include is the using of the blue stone: The story of ‘lahass alkharaz لحاس الخرز~~

6.4.2.1 Abo Ahmed the son of the “ironing man ابن علي ياكوي

Abo Ahmad, a 70-year-old Saudi male, told one of the most interesting stories that I heard in the interviews. Abo Ahmad called himself the son of the “ironing man *Ibn Elly Yakyewy* ابن علي ياكوي. He comes from a long line of traditional healers and has personally experienced the old practices, which vary in nature in Saudi Arabia and throughout the Middle-East. He began by talking about traditional practices for healing, such as reciting Ruqyah from the Qur'an and told me about the principal at the school where he used to work who read it to individuals and groups. Abo also related stories about the traditional practices used when he was growing up in Saudi. As a practitioner, I can deduct from his stories that the people who were involved were facing mental health issues, but to him, they were “Mo Tabee'en مو طبعين” abnormal humans. It is necessary to include the whole narrative as it such a powerful example of cultural healing practices and their impact on those involved. Abo explained:

Sometimes he held people by the shoulder and spilled holy water down on them and made them soaking wet in winter. You know cold it gets in South Saudi?

[When he was treating them with the hot piece of iron] they didn't feel a thing. I could actually smell meat [their burning skin]. He ironed people on their head in a certain spot, he is doing that [measuring with his hand] at a specific spot. I don't know how he figured it out!

I watched these things!! And I had to restrain the people. My father even asked them, “Hey, let me know if you feel something”, but they didn't!! The suffering that I have been through watching everything, its wrong. “Haram” that I got to watch my father “yakwie” with the hot iron pole, it looked like this chair's leg in density, until its colour becomes like [he was out of breath and pointing to a fiery red notebook on the table to describe the colour], like

“Jamrah جمره” [a red, burning piece of charcoal]. Exactly! You see, mentally unwell people “عابدين Ta’baneen” came to him. And then I came to hold them [as his role in this] while I was really young! And he put them [the hot iron pole] on the person’s feet, of course, they didn’t feel a thing!! There is a certain place in the human feet [where they do not feel a thing], but now it’s scientifically discovered with the devices and research technology. And when he ironed them on the head, smoke came from their mouths!! While they were not smoking [cigarettes]. Something I will never be able to forget!!

I watched these things!! I always ask myself how did the first ancestors live, may God have mercy on them. They were dark ages, I saw more than what anyone saw, but they survived!! A person I knew, my father had ironed him, it seemed to me that pole was going to go through his head, but he said to me once, “Without God and that ironing, I wouldn’t be well and would not have made it [career-wise] like this right now!

Listening to Abo Ahmad’s story on the recorder and translating it helped me to analyse it better. After the interview, I was overwhelmed by that story. I remember I needed to take a long walk to gather my thoughts. Being an insider-outsider made me realise that even though I had heard similar stories before, this interview had given me a much deeper insight into how Abo Ahmad was personally affected by what he saw. I could see that he was caught between seeing the usefulness of this healing practice, but at the same time being traumatised by it. It was my duty as a trained counsellor to make sure that he was alright after the interview, but as a researcher, I had to maintain my professional boundaries and refer him to a GP that speaks Arabic for further assistance. I also left him with the number for Lifeline and a few other contact numbers for support. It was a challenge for me to watch someone expressing pain in a way they have never done before. I called his daughter a few days afterwards to check on him, and she said,

“This was the first time in my life to hear or see my father’s pain”. His daughter confirmed my research questions and hypothesis about mental health literacy and how hard it is for men in the Arabic-speaking community to express pain or mental health issues such as trauma.

Abo Ahmad’s story was a stepping stone in confirming my thinking: if a practice does no harm, it should be considered when dealing with mental health issues, but if it does more psychological and even physical harm, how do we deal with it? Flamm (2004) reports that "It is often claimed that faith healing may not work but at least does no harm. In fact, reliance on faith healing can cause serious harm and even death." (p. 70). I agree with this opinion. In many healing practices, if they are not invasive and help people, they should be utilised. Reiki is an example of this, as some studies have found evidence that it is helpful. In a three-year study, Birocco et al. (2011) found that “Reiki seems to be a promising aid in anxiety control”. A further example is the blue bead, “Kharaz Azraq خرز أزرق”, which forms part of another cultural practice, as described in Section 6.4.2.2.

6.4.2.2 The story of ‘lahass alkharaz لحاس لخرز

There are many tales in Arab folklore about cultural healing and mental health. I asked my grandmother, Omnia, if she knew of any, and she told me the following story:

Historically, a man was known among African asylum seekers, who licked evil beads ‘lahass alkharaz لحاس لخرز’. He used to come at Hajj times [the pilgrimage to Mecca] and bring those beads, which turn people into an insane crazy person [when he licks them], but the blue bead, in contrast, which comes from Turkey and Egypt, we used to wear them with ‘Mu’tat معوذات’ being cited on it. We believe it takes “Hassad حسد” away, but there are some people who believe it just brings luck and sanity.

As for the “Hassad حسد”, people mean a person can have such an evil power to envy them or someone to the point that some harm can affect them. Arabic-speaking community has this cultural understanding hand down from generations of the Bedouin ancestors who lived in the desert as Al-Krenawi (1999) states that “It serves as a crucial mechanism to explain social problems, envy, bad luck and misfortune in the uncertain conditions of the desert environment.” (p242). I have explored Hassad and Alayen in the beginning of this chapter, and using this cultural intervention is basically to prevent evil eye. These cultural practices that the Arabic-speaking community use, “the blue beads ... serve as protection against the evil eye” (248). Whether is the bead alone, ornamented in jewellery like the *Hamsa hand* as in Figure 8, or ‘combined’ with Ruqyah as *Omnia* stated before, brings me to the conclusion that such cultural practices have played a major role in the way Arabic-speaking community view mental health and healing. It is apparent that some of these practices could work, whether is it a placebo effect or the person deeply believes in such power, using this knowledge about healing could help practitioners.

The result of a systematic review by concluded "sixteen articles met the inclusion criteria. Despite methodological limitations, there was evidence from the papers that stakeholders perceived traditional and/or faith healing to be effective in treating mental illness, especially when used in combination with biomedical treatment." (Van der Watt et al., 2018, p. 555)



Figure 8. Photo of the blue stone, “Kharaz خرز” from my personal jewellery collection

6.5 Conclusion

This chapter explored participants’ religious beliefs and practices, illustrating that many interpreted and perceived mental health issues – such as psychotic symptoms like hearing voices – as Jinn جن (Djinn) or demonic possession. This is confirmed by Seher & Rabtt, who found that سحر و بيط or black magic and spells (or sorcery) was how participants interpreted uncommon behaviours, which western clinical psychiatry may explain as resulting from mental illness conditions.

Exploring frameworks that balance the involvement of religious healers and leaders with mental health trained professionals may have positive outcomes, raising awareness about mental health and increase the possibility for people getting the right support on their terms. From what participants shared, it is important to understand that having a spiritual outlook is important to hold onto, as it adds value to the members of the Arabic-speaking community; as well, religious healing and the Sheikhs and leaders who are offering it represent a great asset, provided they were trained in basic mental health awareness, knowledgeable about symptoms and signs and are willing to refer community members to appropriate support services when needed.

Combining traditional healing and Western approaches to mental health has been explored by other research as important for dealing with mental health in religious and traditional communities; based on sixteen articles, a systematic review by Van der Watt (2018) concluded that “there was evidence from the papers that stakeholders perceived traditional and/or faith healing to be effective in treating mental illness, especially when used in combination with biomedical treatment.” (p. 555). As some of participants in this study suggested, people who hold religious beliefs and a strong sense of God or a higher power are more likely to overcome the negative effects associated with mental illness.

The next and final chapter will integrate and discuss these findings and relate them to the factors contributing to mental health literacy in the Arabic community.

Conclusion

Chapter 7: Understanding mental health Literacy in the Arabic-speaking community

7.1 Introduction

In this concluding chapter, I reflect on the methodological underpinning of the thesis and review the research questions to summarise the findings to respond to key questions such as how does the Arabic-speaking community identify emotional distress or mental health issues, with consideration to culture and religious; as well as on mental health disparities, help-seeking attitudes and the needs of the community. This review and findings will primarily contribute to the existing body of literature around mental health literacy, and particularly with regard to mental health literacy in the Arabic-speaking communities.

I started this research in 2015 to follow my passion for raising awareness about mental health. I was keen to further increase my own understanding and improve the body of knowledge about the Arabic-speaking community in Melbourne. Unpredictably, each year that passed, the themes of the thesis became more and more complex, the insights more profound, curious; yet also more enlightening. Deep discussions and seminar sessions with my supervisors also helped me greatly to reframe the emerging themes of my thesis; whilst also helping me to clarify my own thinking, insider-outsider role and fieldwork and analysis. Over time, I found myself being able to engage more deeply and relevantly in this research as both a practitioner/researcher and a vibrant member of the Arabic-speaking community.

This thesis has been an interesting journey for me. It allowed me to have a deeper understanding of mental health among the Arabic-speaking community, and I am very thankful for their willingness to let me into their lives. It has also highlighted the importance of this research for the Arabic-speaking community itself – as a reflexive understanding, like a mirror, of where their own perspectives and thinking is at; and how it affects their understanding and abilities to access assistance in their new migrant country.

Overall, as I indicated above, I kept seeing similar patterns of reacting to mental health literacy in the community. The shared meanings, perceptions and views about mental health literacy were not an abstract awareness; rather it permeates everyday life, for example, in acknowledging your son's ADHD or, isolating yourself when you go through depression. I have critically looked at the religious and cultural beliefs behind mental health, and analysed how these beliefs play a major role in the way the Arabic-speaking community perceived and viewed mental health. Even though I was very careful not to allow my views and perceptions to affect the way my participants responded to my surveys and interviews, I found that these beliefs and perceptions would eventually be very critical in how they are ~~could be~~ utilised to help elevate mental health literacy and enhance the awareness around it, in a culturally sensitive manner.

7.2 Reflections on the methodological and theoretical underpinnings of this thesis

The thesis grapples with many theoretical concerns, views, beliefs, perspectives and understandings that are held by the Arabic-speaking community of Victoria.

There was a corresponding amount of theoretical groundwork to cover in order to faithfully understand an area that was not represented nor researched in a large scope of studies. Hence, my position as an insider-outsider have helped me to access deeper insights as I gained trust and a increasing interest in the research I was undertaking. It has certainly contributed enormously to the way I have tried to analyse my findings and present them in coherent and useful ways.

While much of the theoretical groundwork has been linked to the analysis and findings unified in Chapters 5 and 6 as appropriate, the methodological considerations require some further elaboration. Primarily, I want to offer some reflections on the way I employed autoethnography and narrative analysis throughout the study. This form of narrative analysis served me very well as the means to examine the stories presented by the research participants thoroughly and critically. I treated narrative analysis as a lens through which to examine and potentially uncover the drivers and forces behind these stories. I believe autoethnography has helped me to uncover many of the shared experiences the participants trusted me with; in which kept reminding me of my position as an insider-outsider. And that position was at times extremely difficult to handle due to aspects of the stories I was told; some

stories were heartbreaking and highlighted the grave impact of mental health on the individual and the family and extended members of the family. It was both challenging and personally difficult to work through these narratives. But it has been paramount in these deliberations that I was constantly careful of maintain the integrity of these narratives; respecting their trust in telling me their stories, whilst also being methodological in analysing them for the purpose of this thesis. Further discussions with my supervisors also helped me to debrief and reflect on my fieldwork and its rigour, and also unearth the immensely helpful insights gained from an insider-outsider location in my thesis.

These narratives have revealed much about how members of this Arabic-speaking community view mental health, something many people from Arabic-speaking communities may have not been able to do when talking about mental health. This research experience more deeply instilled in me a profound respect for the battles mental health inflicts on people's lives, as they navigate their way through difficult emotional experiences, memories, complex structural constraints, and excruciating pains of stigma and "Ayeb". It was a privilege to be given intimate access to their private lives, views and beliefs, especially in such a short period of the fieldwork that lasted eight months in my case.

7.2.1 Challenges in the thesis

I came to this research having great amount of worries around talking to the community about mental health issues. From my previous experience researching this area as a master's thesis, people were not very keen to talk about mental health in the Arabic-speaking community. My findings have confirmed that, mental health issue is "unmentionable" **مكتلم عنه** and getting people to participate in the research may seem hard. However, I found the use of the community engaged methodology, coupled though the online survey to be immensely helpful to get to the voices of the community. Studying the Arabic-speaking community from Saudi Arabia has provided me with very good indications of the way people look at mental health issues and helped me to understand similarities between the Arabic-speaking communities. I have also faced many technical challenges when translating interview transcriptions between Arabic and English. I have tried to use this challenge as a stepping stone to gain more understanding and in analysing what people shared with me in the interviews and the online survey. Another challenge I faced was maintaining the balance between being both an insider and an outsider;

at times I had to separate myself as it was a very fine line to walk every time I was sitting with a participant.

While the narratives that I was hearing were important, it was very challenging for me to try and look deeper into the meaning of these stories and find what is related to this research. As Kim, J. (2017) posits, narrative methods do shed light on darkness and suffering from a researchers perspective. Alas, while there were very many meaningful stories to share with the world, I had to choose very wisely which ones are more related to the research questions I had.

7.2.2 Reflections on the processes and conclusion

This research used an approach that is underpinned by a community-engaged research methodology and examining culturally sensitive research fields like mental health and CALD communities. Drawing on the research process and data from that, have helped to gain an understanding of sensitive issues like mental health, which required giving the community the space to make their own definition and meaning of mental health literacy, rather than imposing ontological measures, that has been applied through a Western lenses of understanding mental health literacy in non-Western communities. Taking an autoethnographic approach; the interactions with the community were useful to address my “insider” status, and while not imposing, it has provided a safe and comfortable space for participants to relate and voice their views and ideas. I have noticed men were comfortable enough to take part in the interviews, as I had in mind the cultural aspect of interviewing men as a woman.

As previously described, the research plan aimed at keeping the balance between female and male participants, but I had to keep in mind the traditional and cultural barriers. I thought gender divisions will make it difficult for me as a researcher to discuss a range of issues around mental health literacy, but I was surprised that many men were comfortable, answering question. Interviews with especially an elderly man Abo Ahmad provided some very valuable insights and also gave me a greater understanding and insight into men’s perspectives and

responses in their lives. Women on the other hand, were not only comfortable sharing stories, and in many cases, symptoms of mental health issues they experience, which have hopefully gave them enough space to seek support, as I encouraged them and referred them to a health practitioner whenever they shared that. Although I conducted my fieldwork in Melbourne, rather than in the Middle East, I was surprised how familiar the experiences of the participants were to me, despite having lived for the last 11 years in Australia. This showed me that even when we inhabit a world and think we don't belong any more to our culture, and that somehow living in a different "land" would mean you don't know a thing about the people, it made me realise and understand, that the parts of me that "belongs" will forever be in my home country Saudi Arabia. These aspects and elements were more thoroughly examined through taking an autoethnographic approach.

This approach also helps to affirm that any belief or idea is created by meanings and experiences that are encountered by people within their given community. The community-engaged research methodology further helped this research to explore the mental health literacy of the Arabic community without endorsing a prescribed theory of knowledge or view of reality. This was achieved through a theoretical exploration of the grounded theory as a framework, and strengthened in the fieldwork (both online and interviews) that is grounded or rooted through an insider-outsider autoethnographic methodological approach.

7.3 Summary of the findings

The finding of this research reflects on the main questions I had when I started the research; to understand mental health literacy in the Arabic community. Although the findings were illustrated in a coherent connected way in Chapters 5 and 6 alongside the analysis, I will summarise them with the related research questions in the upcoming section.

7.3.1 Answering the research questions

One of the main research questions was:

- What is the impact of cultural factors on mental health literacy; that is, attitudes, beliefs, knowledge and skills?

Firstly, it is worth noting that the cultural factors in this research were the participants' attitudes, perspective, beliefs, knowledge and skills that were constructed in the context of many cultural influences and diverse belief categories. I started the research with no limitation on the participants' backgrounds as Arabic speakers are already a minority in Victoria (1.4%) (ABS). However, most of the survey respondents and the interview participants were from Saudi Arabia; and at that point, I found myself learning to be an insider-outsider

The main themes highlight how cultural factors impact the way people perceive mental health in different ways, compared with Australians with western cultures or Anglo-Saxons. It brings me back to theoretical ideology surrounding Migrations and transnationalism impact on health and wellbeing, which was discussed in Chapter 4 literature review.

Many of the participants have expressed views that confirm that stress and emotional difficulties are understood and treated differently where they come from; which confirms that Australians with Western cultures or Anglo-Saxons background have different perceptions about mental health than Arabic speakers. Consequently, as some of the studies cited in Chapter 4 suggest, there is a difference between the mental health and the physical wellbeing of individuals post-migration (Coffey et al., 2010), or, as Percy & Keppel (2002) refer to it, there is a health disparity.

The participants have seen wilful blindness as one of the ways to ignore mental health issues describing it as “unmentionable” *ممنوع*. Some of the participants think of people with mental health issues as crazy “majnoon” *مجنون*. It seems like many of these ideas are experienced by some of the community members from a young age. Some people also talk about destiny and

fate or what's been written by God “قضاء عوقدر نصيب”. It seems that Islam, as a religion, has a great influence on the Arabic-speaking community that is originally from Saudi Arabia.

Cultural attitudes and beliefs are very apparent in the way people view mental health issues. This fact is highlighted in some of the theoretical perspectives of health disparities as discussed in Chapter 4, and confirms what scholars such as Kreps and Sparks (2008) argue, which is that communities from diverse cultural backgrounds are more vulnerable when it comes to understanding and dealing with health issues. It is apparent from the views the participants shared that these cultural beliefs and attitudes are strongly linked with health disparities.

Health disparities have apparently played a role in perceiving with mental health issues and people experiencing it in the Arabic community, It is not uncommon to describe someone with mental health issues as “Majnoon مجنون”. Cultural beliefs and attitudes have also been dissolved in people wilfully ignoring to talk about mental health issues. In many cases, I found that even though people know that is a mental health issue they would still refuse or choose not to talk about it. Previous research has shown that such ignorant will result in delays in seeking appropriate mental health interventions regardless of their availability. This will be addressed in the section on service provision and service access, which is something I did not intend to address in this research, as my focus was to see how culture and/or religion plays a major role in the way people deal with mental health issues. I have come across the Islamic views and beliefs around such issues in Islam it actually is apparent as mentioned in Chapter 5.

I found out that when people perceive someone with a mental health issue as “majnoon مجنون” or crazy that results in a significant amount of disturbance to their life, to their social status and to their relationships.

The Arabic-speaking community believes mental health issues may be the will of God. I tried to ask about such experiences to go deeper into their belief systems, especially when it came

to believing in “Qada wa Qadar قضاء وقدر” but unfortunately it’s a very sensitive area to explore.

However, from the views shared by the participants in relation to religious beliefs, and how they play a role in supporting people during mental health adversities or issues, it seems like religion or spiritual beliefs give people a sense of hope and living for the future; they believe that what is meant for us by God will happen. This has played a major role in helping them to get through difficult times.

One of the other cultural factors that I found when dealing with mental health issues is “Hassad” Evil eye; it seems like a deep belief that many of my participants shared throughout the data collection. Table 3 in Chapter 6, which shows the differences between some of the Diagnostic criteria for depression and anxiety in comparison with “Hassad” Evil eye, will be a useful reference for future research and practise when dealing with Arabic-speaking clients. I undertook detailed reviews of sources from Arabic scholars and international scholars and my cultural background and insider position have helped me to understand the symptoms as I have experienced some of them with close family members. These symptoms are something I explored personally and I have shared some of the stories in this research. I am hoping that one day to people in the Arabic community have the courage to share their stories; as they will help to improve the knowledge around mental health issues.

One of the other areas that came as a very important factor, also shared by many other CALD cultures not only the Arabic-speaking community, is stigma and shame, something that has been stated and noted by many other researchers (Corrigan et al., 2012; Reavley, 2011). However, in the Arabic-speaking community, it is even more magnified as the research participants have stated in the survey and interviews that stigma “Aybe” is the main reason they would not want to acknowledge mental health, they will try to avoid it, so it is “unmentionable حرام ذكره”.

The participants stated that they do not want to be perceived as weak or crazy or stupid. My findings demonstrate “Mjnoon” as having a significant impact on people’s views when dealing with mental health issues. It also has impacts on personal relationships and their daily life. Hence, this is a very important aspect to consider when talking about mental health literacy in the Arabic-speaking community.

Another important aspect of the cultural barrier is “manhood”. If you are male in the Arabic-speaking communities, there are certain rules that are placed upon you and I found that men in the Arabic-speaking community tend to “act” strong, so they are perceived as invincible and not weak, as culturally they consider themselves the guardians -historically providers- of the family.

7.3.2 Reflection on some unexpected findings/observation

While the findings detailed above were the deliberate focus of the research questions, there are several points to which I wish to draw attention, as they were unexpected findings of the research.

Firstly, the respondents spoke to me at length about their fears and worries about the topic, whether it is because of their lack of understanding about mental health issues, or their personal experience with it, I did not expect them to be willing to share such hard worries with me, people tend to try to seem in control, strong and not affected by adversity which is typically driven by fear of stigma. This has implications for practitioners aiming to help non-western patients with mental health issues. It also adds to the body of research about stigma and trust to discuss mental health issues (Reavley, 2011; Scambler, 1998).

Secondly, I expected that Arabic as a language would play a major role in the participants’ understandings of mental health. On the contrary, it is not something mentioned by the

participants, although other researchers note that "...language can be a powerful source and sign of stigmatisation." (Rüsch, Angermeyer & Corrigan, 2005, p. 530). I believe that mental health as a western concept will definably face challenges in which translation will come to aid. But my findings confirm that there is an urgent need for culturally competent resources and approach which I will discuss in the final section. In my view, the Arabic language, although rich in context and vocabulary, may fail people to express their emotions. It is not due to the lack of vocabulary, but merely the lack of bravery and acceptance for people to express their feelings and emotions. I know that it was normal for us for example to express our emotions as "Za'alan ضال" which translates to (sad- agitated- angry- upset- frustrated- annoyed) which ironically refers exactly to any of the above emotions! The participants showed a lack of understanding about many different feelings in Arabic which is an important area for further research about the relationship between expressing emotions in the Arabic language and mental health literacy.

A final unexpected finding was the sense of openness that male participants had towards stories they never shared before with anyone before me. This does not accord with the stereotypical expectations that I had in mind growing up in a traditional Arab society, and indeed, it confirms what I found about the correlation between the education level -per the findings in Chapter 6 and Appendix 7- and their awareness and openness about mental health.

7.3.3 MENTAL HEALTH DISPARITIES, HELP-SEEKING ATTITUDES AND THE NEEDS OF THE COMMUNITY

Another main question I had aimed to answer was:

- What is the impact of mental health literacy on help-seeking behaviours?

The finding suggests that the lack of understanding of mental health- literacy- plays a major role when it comes to help-seeking attitudes. After the thorough review of the literature many

Western research findings (Gulliver, Griffiths & Christensen, 2010; Han & Pong, 2015; Jorm et al., 1997; Kayrouz et al., 2014) suggest that there are some approaches to improve mental health literacy.

One main point is educational approaches that include information resources and educational sessions and training; for example: books, flyers, videos, mental health workshops. It has been found that it challenges common negative stereotypes toward mental health and replace them with information (Jorm, 2000). This finding correlates with my findings about the role of education in improving mental health literacy.

Another method to improve mental health literacy is “Contact approaches” (Corrigan et al., 2012), which includes face-to-face contact, such as support groups, with people who have mental health problems or who are working as clients’ advocates. This may seem like an excellent approach but given the nature of the Arabic-speaking community when dealing with mental health and how wary they are around it, this concept aligns with the health disparities concept covered in Chapter 4. It seems that the help providers require more work to establish a culturally competent approach.

This research has helped to shed light on the way the Arabic-speaking community view mental health, which consequently leads us to ask about help-seeking attitudes and service access, which have not been the focus of this thesis, as previously mentioned.

But keeping mental health disparities in mind, improvements in mental health education or stigma-reduction strategies need to be developed and implemented in a collaborative, culturally sensitive and multi-sectoral approach. These culturally sensitive approaches should be led by people from the Arabic-speaking community, who are either bilingual and/or bicultural with experience around mental health issues and be supported by system-level reform and policies that are still to be developed in services provision in Victoria.

As most participants interviewed stated that Arabic-speaking community tend to view “Ayeb” as a major obstacle to mental health literacy which leads to underutilisation of mental health services whether it is multicultural driven or public Australian services. Their feeling of social stigma and embarrassment in relation to mental illness automatically places them on the perimeter of their community and therefore outside the bounds of normality, which may ostracise them from the whole society.

The lack of culturally sensitive or competent care is an additional barrier that I have witnessed through my work as a practitioner in NSW and briefly in Victoria. There is no doubt that racial and ethnic minority groups have been underserved in the mental health services sector (Furnham & Hamid, 2014; Takeuchi & Uehara, 1996). Participants in this research study also spoke of their reluctance and much discomfort about using the mental health system in Australia. These views have been confirmed in other studies as well around Arabs in Australia (Kayrouz et al., 2014; Slewa-Younan et al., 2014). The lack of attention to cultural sensitivity and the effects of language barriers continue to impact the provision of mental health care to people from Arabic-speaking backgrounds. In recent years, models of cultural competence have been developed such as the Cultural Competence Process Model defined by Campinha-Bacote (2002) as “the Delivery of Healthcare Services are cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire” (128) which has been applied to the care in many mental health service providers’ framework. However, there are still large gaps in integrating culturally sensitive practice and knowledge, and culturally competent skills into policy, services, and clinical practice of health professionals leading to low service access (Awaad, 2003). This gap is primarily mental health literacy.

As Jorm (2000) argued within the Australian context, the main goal of the mental health services is to get the client/patient out of the service as quickly as possible. Hence, people from Arabic-speaking background may not access services –or culturally competent- due to the lack

of enough understanding around mental health issues and the usefulness of therapy, besides other cultural and religious factor that may be influencing that traditional Western service (psychology, psychiatrist). My argument is that potentially, if we want to reduce prevalence, especially within CALD communities, prevention is the answer. Prevention is aimed at reducing the number of people that get into the services. It seems like Australia has put most of the resources trying to get people out of the service and very little into trying to prevent people getting in

Due to the potential cultural factors impacting the mental health literacy of the Arabic-speaking community, which were discussed earlier in the analysis and findings of this research, any plans or efforts to improve mental health literacy - by government agencies or support services, must consider the internal cultural and linguistic diversity within the Arabic community.

In this contemporary society, we know that prevention is better than cure. It is quite the norm to vaccinate against illnesses like polio, diphtheria, measles and whooping cough. We have awareness campaigns for melanoma, stroke, and diabetes. But none of those conditions come close to affecting 25 per cent of us. 1 out of 4, that is the Australian current general mental health problems rate. This made me wonder why there is no prevention campaign for mental health issues. The leading cause of suicide which WHO estimates that it killed a person every 60 seconds (WHO, 2001).

Hence, policymakers need to pay more attention to emotional health and mental wellbeing and prevention of their community.

The other question that I asked is:

- In what ways does culture inform and influence perceptions of mental health literacy?

The participants had a deep engagement with culture and religion. Many described it as a factor that shapes the way they view mental health. Arabic-speaking community members are inclined not to talk about mental health issues in general. They are more likely to attribute symptoms to supernatural schema.

Arabic speakers are susceptible to missing out on mental health services due to many of the cultural and religious factors that hinder their acknowledgment and understanding of mental health issues. Other notable factors that contribute to this susceptibility include language problems, cultural stigma, unfamiliarity with Western health systems, and the overall lack of culturally competent health services (Al-Krenawi, 2002; Aloud & Rathur, 2009).

Contrary to Western therapeutic approaches which stress on the individual when offering therapy; therapeutic intervention with Arabic-speaking community members need to be couched in the context of the family, community and culturally sensitive manners. This is because Arabic community has a high value for family and friends there is a sense of collectively when researching them

7.4 Locating and dislocating myself

Throughout this research, I have often wondered about my positions as an insider-outsider. Do I let me experience be present or not? How do I maintain integrity and keep watching for biases?

I found myself in the “rumbling” as Brown (2015) talks about in her book, “the rumbling begins with turning up our curiosity level and becoming aware of the stories we are telling” (p.87). She talks about the space we hold for curiosity, which was for me dislocating myself at some point to be pulled back to locating myself. This curiosity and rumbling were the canvas that allowed me to see deeper in many theories, ideas and beliefs I held about the community and their understanding of mental health literacy. Curiosity, rumbling and wondering was the

perfect potion to shedding light and recording many aspects about mental health in the Arabic-speaking community that were not explored in such depth in which I encountered. I found myself dislocating my identity as an Arabic-speaking researcher to be purely objective, practitioner and women to rumble with questions about the bridge that needs to be formed between culture and mental health and what the future of the Arabic-speaking community in Australia looks like when these bridges are made.

Locating myself in the research have made me go through and insider-outsider variations that I would like to conclude by mentioning some points on locating and dislocation myself, in other words, being an insider-outsider. I was offered extra information by the community given the knowledge that I shared with them. Hence, the interactions between me and the participants of the research were more culturally acceptable because I am from the community. This was also argued by Greene (2014) in her work about the insider research. I needed to observe my position in this research throughout the data collection phase; but this approach was challenging me to locate myself consciously at each stage, and as (Nadarajah, 2007, p. 112) explains “One of the problems with this method is that the distinction between "outsider" and "insider" becomes ambiguous, and the skill and epistemological distinction between two distinctly different cultural knowledges” which in my case was the personal knowledge and experience being an Arabic-speaking women and the knowledge and experience I hold as a partitioners.

But through community-engaged approaches, being an insider from the community have given me the privilege of interacting closely with community members. While engaging the community, questions for the survey were successfully put in more culturally acceptable and reachable ways. Talking the “cultural language” helped me to gain deeper findings, also being an insider and locating myself in the community have gave me a better access to participants. I found it easier to ask people to participate when they are more able to communicate with me,

and the sense of the insider knowledge they had in mind about my background or in some cases word of mouth from people who attended mental health training that I ran.

When I started collecting the data from interview participants, I had to keep in mind the best way to tell and honour the stories the participants shared with me. I then used autoethnography, some critics may argue that I am an insider and my view is subjective and biased. By understanding this point from the very early stages of this research, I stated my position and locate and dislocate myself from the research as need arises. For example, during interviews, when I posed a question that I was well aware of the answer like “what are some cultural barriers the Arabic community hold toward mental health?”, I had to remind the participants that I may know what that means but I am more interested in knowing their views. I know that insider-outsider research may be criticised as to be too close to the culture or participants’ experience, but I was monitoring my thinking and I was locating and at some points dislocating myself by writing notes to help me monitor bias and check my personal views while being open and honest. It is argued that being an insider may be the source of knowledge as well as the potential error, but I was aware of the potential of that through conducting this research. I learnt that by gaining knowledge and making mistakes, and learning from them, we can create research that is driven by integrity, regardless of the challenges of maintaining objectivity when located as an insider-outsider.

The best way I overcame this challenge was to dislocate myself from the field as needed and by sharing my own experience with colleagues and supervisors. I maintained observing my own views by taking notes constantly and consciously. Also, to overcome these challenges, I have maintained credibility by sharing the notes and peer debriefing and sharing information with my supervisors and mentors. I maintained full transcripts of the interviews in both languages by avoiding stereotyping and judgments that is culturally perceived in my

community (e.g. openness to women who wore niqab). Furthermore, sometimes I had to practice interviewing myself and asking other college questions from purely an outsider position. Finally, I knew that my position in this research may be criticised as Nadarajah (2007) states “As an insider too, I understand that I will be frequently judged on insider criteria – family background, status, politics, age, gender, religion” (p. 126) but I knew as an inside-outsider, this research has gained insight and authenticity about mental health literacy, an area that is so sensitive in the Arabic-speaking community. Throughout this journey I thought that as an insider (part of the community) outsider (researcher and practitioner) was a weakness. But as this research unfolds, I was made to be aware and learn that it was a strength that helped in highlighting mental health literacy in the Arabic-speaking community.

7.5 Avenues for further research: how can we raise awareness about mental health in the Arabic community?

While studying, practising and researching mental health within culturally and linguistically diverse community, I have come to realise many aspects and factors involved in the mental health literacy.

Many western studies have suggested ways to raise awareness about mental health. In a WHO simulation conference organised by Melbourne University in October 2018, Anthony Jorm, a mental health literacy pioneer was presenting his recent work about mental health literacy and awareness around it. In his latest study, he talked about the gap that I too am keen to understand between the availability of service and the prevalence of mental health. The study found that “the large increase in the use of mental health services after the introduction of the Better Access scheme had no detectable effect on the prevalence of very high psychological distress or the suicide rate” (Jorm, 2018, p. 1057). It seems like even though service provision improved for Australians through the mental health better access scheme, but that have not decreased the numbers of life taken by suicide according to the ABS comparison that Jorm indicated in his

study of the suicide statistics before and after this scheme was introduced but such studies often ignore structural factors and focus only on the individual. If that is not the solution, then many other studies that are looking at CALD mental health are still suggesting specialised care that is culturally competent and sensitive. I believe that is crucial to deliver a suitable solution to increase service access to specialised and professional care. However, this research has found that literacy and awareness is the gap that is making people not access the available services. The research participants have concluded the survey by answering a question about how we can raise awareness about mental health. I found that the very first idea I came to believe about the importance of mental health education was confirmed by my four years of professional work and the more than 100 participants in this research.

In conclusion, having a spiritual outbound and a rope to hold on, adds more value to the Arabic-speaking community, and I found that religious healing, and the Sheikhs and leaders who are offering it, would be a great asset if they were trained in basic mental health awareness regarding symptoms and signs, and could refer their clients and community members to appropriate support services when needed. This is aligned with the findings about the combination of traditional healing, culturally sensitive practices and Western mental health methodology.

This Mental health education would consist of a culturally adapted and translated version of the current mental health programs available; mental health first aid, for example, that have been developed in Western agencies for a western audience. Ideally, bicultural and bilingual mental health experts who have knowledge about culture and community would be responsible for producing this culturally modified version.

7.5.1 Culturally adapting mental health education

These research findings have helped me to work towards a plan for a new educational method and hopefully an area for further study. This plan includes creating a reframed mental health education program that consists of three main streams; firstly, an online app in Arabic that is based on the views people share about mental health in this research. The second is an online interactive program available through the app to offer education about mental health issues, signs, symptoms, cultural belief vs. fact and suitable interventions and culturally competent care according to their location (GPS-enabled option). The third stream is a six-hour face-to-face program offering culturally relevant education regarding mental health, which aims to give the community the power of knowledge on their own terms, and will help them to feel more in charge of how they would like to learn about mental health.

In addition, e-mental health has been found to be a useful way of breaking down the barriers when dealing with CALD in conservative societies; for example, Saudi Arabia (Abuzinadah, Binhadyan, & Wickramasinghe, 2018). This research has opened my eyes to a new avenue to pursue in elevating mental health through fighting it with education and knowledge. But this plan will still need to be further investigated as part of this research outcome.

7.6 Final notes

As this research reached the end, I began to understand that my original timelines had been optimistic and that I would have to re-evaluate the logistics of my need for a more diverse group. But some struggles in my personal life also conspired to make this abundantly clear to me after my husband was stranded by military operations in Saudi Arabia, leaving me alone in Melbourne to care –thus raise- my two girls on my own, for the duration of the PhD. I had my elderly parents over for the first 10 months of this journey, but it added an extra layer of care for two more people who had neither the English language skills nor sufficient level of health to be independent in Australia. I was not able to take leave from study due to my limited

scholarship, then I was extremely nervous about the data collection and worried that the rapport I built and the trust I gained through the advisory group and the survey, may fade away. But I was welcomed with genuine empathy and compassion from participants, who knew that I was parenting solo—as news flies like birds in my small community—and I believe that this difficulty in my life helped to connect better to the participants. I was touched by the genuine support my participants showed for me by supportive statements and reminders such “haven underneath mothers feet” *ألا تحت حتي قد دام؟ موات* and the appreciation they felt for such research to delve into many subjects they would not usually talk about.

Throughout this research, I have often wondered about the stories shared by the participants. Do they understand the power of their stories? Do they know that knowledge sharing is key to fight stigma and raise awareness about mental health? And how important do the Arabic-speaking community keep the conversation open about mental health?

It seems that the Arabic-speaking community in Victoria has yet to attain a safe cultural space in which they can connect, share, and ask for better ways to tackle mental health issues. There is no doubt much has been done within the current Australian mental health system, the government funding, NDIS and migration policies, to help elevate mental health literacy nation-wide, but much still needs to be put in place with the rise of mental health issues. It is critical that in the study of mental health literacy within the Arabic-speaking community, the nuances of cultural belief, norms and attitudes are considered and that further research into the areas of CALD mental health literacy and awareness is given greater focus.

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Appendix 1: Ethics approval letters



Design and Social Context College Human Ethics Advisory Network (CHEAN)
Sub-committee of the RMIT Human Research Ethics Committee (HREC)

Notice of Approval

Date: 15 November 2017

Project number: CHEAN A&B 19830-11/15

Project title: 'Mental Health Literacy of the Arabic Community of Victoria'

Risk classification: Low Risk

Investigator: ~~ASSOCIATE PROFESSOR VANDANA JAIN, UNIVERSITY OF MELBOURNE~~

Approved: From: 15 November 2017 To: 3 December 2018

I am pleased to advise that your amendment and extension request has been granted ethics approval by the Design and Social Context College Human Ethics Advisory Network (CHEAN), as a sub-committee of the RMIT Human Research Ethics Committee (HREC). The CHEAN approves:

- Changes to the supervisory team
- Changes to the methodological approach
- Amendments to the survey questions and risk assessment and application form
- Inclusion of a professional transcription service
- Extension of ethics approval to 3 December 2018

The CHEAN also notes the revised participant information sheet and consent form, and confidentiality agreement for use with transcription services.

Terms of approval:

- 1. Responsibilities of investigator**
It is the responsibility of the above investigator/s to ensure that all other investigators and staff on a project are aware of the terms of approval and to ensure that the project is conducted as approved by the CHEAN. Approval is only valid whilst the investigator/s holds a position at RMIT University.
- 2. Amendments**
Approval must be sought from the CHEAN to amend any aspect of a project including approved documents. To apply for an amendment please use the 'Request for Amendment Form' that is available on the RMIT website. Amendments must not be implemented without first gaining approval from CHEAN.
- 3. Adverse events**
You should notify HREC immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
- 4. Participant Information Sheet and Consent Form (PISCF)**
The PISCF and any other material used to recruit and inform participants of the project must include the RMIT university logo. The PISCF must contain a complaints clause.
- 5. Annual reports**
Continued approval of this project is dependent on the submission of an annual report. This form can be located online on the human research ethics web page on the RMIT website.
- 6. Final report**
A final report must be provided at the conclusion of the project. CHEAN must be notified if the project is discontinued before the expected date of completion.
- 7. Monitoring**
Projects may be subject to an audit or any other form of monitoring by HREC at any time.
- 8. Retention and storage of data**
The investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.



Design and Social Context College Human Ethics Advisory Network (CHEAN)
Sub-committee of the RMIT Human Research Ethics Committee (HREC)

Please quote the project number and project title in any future correspondence.

On behalf of the DSC College Human Ethics Advisory Network, I wish you well in your research.

~~Dr David Blaydes~~
DSC CHEAN Secretary
RMIT University
E: dscethics@rmit.edu.au



College Human Ethics Advisory Network (CHEAN)
College of Design and Social Context
NH&MRC Code: EC00237

Notice of Approval

Date: **14 December 2015**

Project number: **CHEAN A&B 0000019830-11/15**

Project title: **Mental health literacy of the Arabic community of Victoria**

Risk classification: **Low risk**

Chief investigator: ~~XXXXXXXXXXXXXXXXXXXX~~

Status: **Approved**

Approval period: From: **14 December 2015** To: **01 July 2017**

The following documents have been reviewed and approved:

Title	Version	Date
Risk Assessment and Application form	1	10.12.2015
Participant Information and Consent Form	1	10.12.2015
Interview question guide	1	10.12.2015

The above application has been approved by the RMIT University CHEAN as it meets the requirements of the *National statement on ethical conduct in human research* (NH&MRC, 2007).

Terms of approval:

1. Responsibilities of chief investigator

It is the responsibility of the above chief investigator to ensure that all other investigators and staff on a project are aware of the terms of approval and to ensure that the project is conducted as approved by CHEAN. Approval is valid only whilst the chief investigator holds a position at RMIT University.

2. Amendments

Approval must be sought from CHEAN to amend any aspect of a project. To apply for an amendment use the request for amendment form, which is available on the HREC website and submitted to the CHEAN secretary. Amendments must not be implemented without first gaining approval from CHEAN.

3. Adverse events

You should notify the CHEAN immediately (within 24 hours) of any serious or unanticipated adverse effects of their research on participants, and unforeseen events that might affect the ethical acceptability of the project.

4. Annual reports

Continued approval of this project is dependent on the submission of an annual report. Annual reports must be submitted by the anniversary of approval of the project for each full year of the project. If the project is of less than 12 months duration then a final report only is required.

5. Final report

A final report must be provided within six months of the end of the project. CHEAN must be notified if the project is discontinued before the expected date of completion.

6. Monitoring

Projects may be subject to an audit or any other form of monitoring by the CHEAN at any time.

7. Retention and storage of data

The investigator is responsible for the storage and retention of original data according to the requirements of the *Australian code for the responsible conduct of research* (section 2) and relevant RMIT policies.

8. Special conditions of approval

Nil.

In any future correspondence please quote the project number and project title above.

I:\Research\Ethics\2015\Letters\Final Approval\Martin, J CHEAN A&B 0000019830-11-15 .doc

Appendix 2: interview questions

- What does mental health literacy in the Arabic language mean to you?
- How does the Arabic-speaking community perceive mental health issues?
- How does the Arabic-speaking community discuss mental health issues?
- What are the religious beliefs around mental health issues in your own religion?
- What are the main support channels for people who experience mental health issues?
- How do you identify if a person is experiencing emotional distress or mental health issues?
- What is the language used to express emotions in Arabic?
- What are the appropriate phrases used to describe mental illness in Arabic? in your daily life? in the past?
- How does language affect your beliefs about mental health issues?
- What is mental health literacy in the Arabic language?
- How does the Arabic-speaking community in Victoria (ACV) perceive mental health issues?
- What are the religious beliefs around mental health issues in the Arabic community?
- How can they identify emotional distress or mental health issues?
- What is the language, expressions and vocabulary used to express emotions in Arabic? How does that impact mental health literacy?
- What is the language used to describe mental illness in Arabic past and present?
- How does all of the above affect the Arabic-speaking community's approach to accessing the mental health system?

Appendix 3: Community groups in Victoria

Birthplace - Ranked by size

Language - Arabic	2016			2011			Change
Birthplace	Number	Arabic %	% of total NSW population	Number	Arabic %	% of total NSW population	2011 to 2016
Australia	88,053	43.9	65.5	83,680	45.4	68.6	+4,373
Lebanon	50,732	25.3	0.8	50,757	27.5	0.8	-25
Iraq	19,868	9.9	0.5	14,549	7.9	0.4	+5,319
Egypt	12,861	6.4	0.3	11,128	6.0	0.3	+1,733
Syria	6,022	3.0	0.1	3,515	1.9	0.1	+2,507
Sudan	3,950	2.0	0.1	3,812	2.1	0.1	+138
Jordan	3,111	1.5	0.1	2,512	1.4	0.0	+599
Saudi Arabia	2,388	1.2	0.0	2,303	1.2	0.0	+85
Kuwait	1,799	0.9	0.0	1,325	0.7	0.0	+474
Gaza Strip and West Bank	1,362	0.7	0.0	1,190	0.6	0.0	+172
Iran	1,151	0.6	0.3	678	0.4	0.2	+473
United Arab Emirates	572	0.3	0.0	351	0.2	0.0	+221
Israel	430	0.2	0.0	482	0.3	0.0	-52
Libya	423	0.2	0.0	457	0.2	0.0	-34
Morocco	333	0.2	0.0	252	0.1	0.0	+81
New Zealand	309	0.2	1.6	259	0.1	1.7	+50
Algeria	300	0.1	0.0	259	0.1	0.0	+41
United States of America	231	0.1	0.4	186	0.1	0.4	+45
United Kingdom	181	0.1	3.6	207	0.1	4.0	-26

Oman	157	0.1	0.0	36	0.0	0.0	+121
North Africa and the Middle East, nfd	130	0.1	0.0	52	0.0	0.0	+78
Yemen	116	0.1	0.0	65	0.0	0.0	+51
Turkey	103	0.1	0.2	111	0.1	0.2	-8
Qatar	90	0.0	0.0	66	0.0	0.0	+24
Germany	85	0.0	0.4	73	0.0	0.4	+12
Canada	81	0.0	0.2	68	0.0	0.2	+13
Tunisia	78	0.0	0.0	66	0.0	0.0	+12
Ghana	73	0.0	0.0	76	0.0	0.0	-3
Afghanistan	68	0.0	0.2	49	0.0	0.1	+19
Venezuela	61	0.0	0.0	60	0.0	0.0	+1
India	59	0.0	1.9	49	0.0	1.4	+10
Bahrain	59	0.0	0.0	59	0.0	0.0	0
Cyprus	58	0.0	0.1	20	0.0	0.1	+38
Greece	55	0.0	0.4	42	0.0	0.5	+13
Somalia	54	0.0	0.0	41	0.0	0.0	+13
Philippines	52	0.0	1.2	25	0.0	1.0	+27
Italy	51	0.0	0.7	32	0.0	0.7	+19
Pakistan	43	0.0	0.3	33	0.0	0.2	+10
Brazil	40	0.0	0.2	50	0.0	0.1	-10
Nigeria	36	0.0	0.0	53	0.0	0.0	-17
Senegal	36	0.0	0.0	42	0.0	0.0	-6
Sweden	35	0.0	0.0	20	0.0	0.0	+15
Indonesia	34	0.0	0.4	53	0.0	0.4	-19
Malaysia	34	0.0	0.4	21	0.0	0.4	+13
Sierra Leone	33	0.0	0.0	27	0.0	0.0	+6

France	32	0.0	0.2	34	0.0	0.1	-2
Liberia	26	0.0	0.0	20	0.0	0.0	+6
China (excl. SARs and Taiwan)	26	0.0	3.1	28	0.0	2.3	-2
Eritrea	24	0.0	0.0	20	0.0	0.0	+4
Russian Federation	24	0.0	0.1	21	0.0	0.1	+3
Colombia	21	0.0	0.1	22	0.0	0.1	-1
Vietnam	20	0.0	1.1	28	0.0	1.0	-8
South Africa	20	0.0	0.6	26	0.0	0.6	-6
Ethiopia	18	0.0	0.0	29	0.0	0.0	-11
Middle East, nfd	18	0.0	0.0	18	0.0	0.0	0
Fiji	17	0.0	0.5	17	0.0	0.5	0
Bangladesh	13	0.0	0.3	6	0.0	0.2	+7
Thailand	13	0.0	0.4	10	0.0	0.3	+3
Uganda	12	0.0	0.0	11	0.0	0.0	+1
Denmark	11	0.0	0.0	10	0.0	0.0	+1
Central and West Africa, nfd	11	0.0	0.0	6	0.0	0.0	+5
Kenya	10	0.0	0.0	13	0.0	0.0	-3
Netherlands	10	0.0	0.2	6	0.0	0.3	+4
Singapore	10	0.0	0.2	6	0.0	0.2	+4
Spain	10	0.0	0.1	13	0.0	0.1	-3
Romania	10	0.0	0.0	14	0.0	0.1	-4
Poland	10	0.0	0.2	8	0.0	0.2	+2

Source: Australian Bureau of Statistics, Census of Population and Housing 2011 and 2016.

Compiled and presented by .id, the population experts.



Appendix 4: Copy of participants and advisory experts group invitation letters



School of Global, Urban and Social Studies

Investigators:

Associate Professor(Senior supervisor)

School of Global Urban and Social Science

RMIT University, Melbourne, Australia.

Professor

Dear Participant,

You are invited to participate in research titled “Mental Health literacy in the Arabic community in Victoria”. This research is being conducted by RMIT University for a PhD thesis. Please read this information sheet carefully and be confident that you understand its contents before deciding whether to participate. If you have any questions about the project, please ask one of the investigators.

Who is involved in this research project? Why is it being conducted?

The lead investigators on this project are Associate Professor Jennifer Martin and Professor Charlotte Williams, Deputy Dean Social Work, who are the senior supervisory team of PhD thesis student Yamam Abuzinadah at RMIT University. The project is approved by the RMIT Human Research Ethics Committee.

This research is being conducted to understand the mental health literacy and the level of awareness around mental health issues in the Arabic community

What is the project about? What are the questions being addressed?

This thesis will aim to reflect a detailed theorisation and exploration through the Arabic community in Victoria of:

- The impact of cultural factors on mental health literacy ie. attitudes, beliefs, knowledge and skills.
- The ways culture informs perceptions of mental health literacy.
- The impact of mental health literacy on help-seeking behaviours.
- The impact of mental health literacy on relationships and community interactions.

Why have you been approached?

You have been approached to be part of this research as you have been identified as someone who is a member of the Arabic community based on the ability to speak and write in Arabic. You have been invited to participate as a member of the Arabic community of Victoria.

If I agree to participate, what will I be required to do?

Involvement in this part of the project involves agreeing to participate in an online survey that will take approximately 30 minutes to complete. The final question on the online survey will ask if you are willing to participate in a face to face interview to gain more in-depth knowledge. If you choose to participate in the face to face interview this will take approximately 45 minutes to complete and with your permission will be audio recorded. The interview will be conducted at RMIT University, a local library or a more convenient location if this is preferred. The survey asks questions about you as a general member of the Arabic community living in Victoria, Australia, and concepts, beliefs, perspectives and attitudes toward mental health. The responses to the questions will be transcribed, collated and analysed by the RMIT research team. All responses will remain anonymous.

What are the possible risks or disadvantages?

There are no perceived risks outside of your normal daily activities. However, if you are unduly concerned about your responses to any of the survey questions you should contact a member of the research team as soon as convenient and they can discuss what action will be appropriate to resolve the situation. You are able to request that any unprocessed information not be used. You will be provided with details of local counselling services if necessary.

What are the benefits associated with participation?

There are no direct benefits to you in participating in this research. However broader benefits of participating in this research are that it provides you with an opportunity to reflect on your experiences in our interview. This will lead us to understand mental health literacy and may contribute to raising awareness around mental health issues. You will also be offered a free voucher (valued at \$50) for a training session around relaxation strategies which will be conducted in 2016, as a thank you token for your time.

What will happen to the information I provide?

Your confidentiality and anonymity will be protected. All surveys will be treated confidentially and stored securely and not used for any purpose outside of the research.

The outcomes from the project may be presented at conferences and published in academic journals and reports. No information will be included which could identify you. This will be achieved by using non-identifying codes for all information collected and any results published will contain group data only.

All information will be kept during the study and stored securely on RMIT University premises and servers for a period of five years before being destroyed. Only the research team will have access to the raw or coded information.

What are my rights as a participant?

As a participant in this research, you will have:

- The right to withdraw from participation at any time.
- The right to have any unprocessed data withdrawn and destroyed, provided it can be reliably identified, and provided that doing so will not increase the risk to you.
- The right to have any questions answered at any time.

A summary of our research outcomes will be provided to participants, if they wish to receive it. Please feel free to call any members of the research team if you have any questions or concerns, or if you would like to discuss any aspects of this research.

Thank you very much for your time.

.....

Associate Professor

School of Global Urban and Social Studies

RMIT University

Melbourne VIC 3001

Ph:

Email:

Professor

Senior Lecturer, School of Global, Urban and Social Studies

RMIT University, Melbourne, Australia.

Yamam Abuzinadah PhD Research Student Investigator

School of Global, Urban and Social Studies

RMIT University, Melbourne, Australia.

Any complaints about your participation in this project may be directed to the Executive Officer, RMIT Human Research Ethics Committee, Research & Innovation, RMIT, GPO Box 2476V, Melbourne, 3001. Details of the complaints procedure are available at:
http://www.rmit.edu.au/rd/hrec_complaints

CONSENT

1. I have had the project explained to me, and I have read the information sheet
2. I agree to participate in the research project as described
3. I agree:
 - to undertake the tests or procedures outlined
 - to be interviewed and/or complete a questionnaire
 - that my voice will be audio recorded

4. I acknowledge that:

- (a) I understand that my participation is voluntary and that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied (unless follow-up is needed for safety).
- (b) The project is for the purpose of research. It may not be of direct benefit to me.
- (c) The privacy of the personal information I provide will be safeguarded and only disclosed where I have consented to the disclosure or as required by law.
- (d) The security of the research data will be protected during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to RMIT University. Any information which will identify me will not be used.

Participant's Consent

Participant:

Date:

(Signature)

School of Global, Urban and Social Studies

Dear

You are invited to be a member of the advisory group to provide expert advice on research titled “Mental Health literacy in the Arabic community in Victoria”. This research is being conducted by RMIT University for a PhD thesis. If you have any questions about the project, please ask one of the investigators.

Who is involved in this research project? Why is it being conducted?

The lead investigators on this project are Associate Professor and Professor who are the senior supervisory team of PhD thesis student Yamam Abuzinadah at RMIT University. The project is approved by the RMIT Human Research Ethics Committee.

This research is being conducted to understand the mental health literacy and the level of awareness around mental health issues in the Arabic community

What is the project about? What are the questions being addressed?

This thesis will aim to reflect a detailed theorisation and exploration through the Arabic community in Victoria of:

- The impact of cultural factors on mental health literacy ie. attitudes, beliefs, knowledge and skills.
- The ways culture informs perceptions of mental health literacy.
- The impact of mental health literacy on help-seeking behaviours.
- The impact of mental health literacy on relationships and community interactions.

The project will be informed through a three-stage inquiry:

If I agree to participate, what will I be required to do?

If you agree to join the reference group for this project you will be asked to participate in three meetings during the project.

Forums for the reference group discussion will include video/audio conferencing if you are unable to attend but still want to take part, it is anticipated to have a discussion around the research which will lead up to a research questioners for an online distribution as a survey and might be used in the in-depth interviews with the research participants. The first meeting will be Monday 29 Aug 12pm–1:30pm in RMIT University Building 80, Level 7, Room 2. (.....) attached is a map.

Thank you very much for your time.

Yamam Abuzinadah PhD Research Student Investigator

RMIT University, School of Global, Urban and Social Studies

Melbourne, Australia.

Associate Professor

RMIT University, School of Global Urban and Social Studies

Melbourne VIC 3001

Ph and email.....

Appendix 5: Glossary of Arabic terms

Term	Arabic	Translation	Meaning
Gusl	غُسل	Ablution	The Islamic ritual of washing and cleansing the body, for different occasions
Wudu	وضوء	Ablution	The Islamic ritual of washing and cleansing the hands, head, face and feet before Salat (prayers)
Iktea'ab	بكئاب	Clinical depression	Sadness, low mood, unhappiness, unmotivated and depression
Tashet	طشت	Wash Basin	Traditional wash basin used for cultural purpose beside home normal use
Mjnoon	مجنون	Crazy	Madness, insanity, crazy or even “abnormal hindrance” to justice or capability in the community or they feel they are not fit to be a law-abiding citizen
Osoul	أصول	Heritage	Family roots, ancestry, heritage or/and origin.
Qada wa Qadar	قضاء وقدر	Destiny and fate	What Allah wills for you
Jinn	جن	Djinn	Romanised as djinn or Anglicised as genies (with the more broad meaning of spirits or demons, depending on the source), are supernatural creatures in early pre-Islamic Arabian and later Islamic religion or mythology and theology

Sihr & Rabet	سحر و ربط	Black magic and spells (sorcery)	Two concepts; one is the spell or the witchcraft that is performed to control husband/wife either to stay loyal or to disrupt and break their relationship, which is culturally a sort of sorcery or black magic that affects their thinking and emotions, in the centre of sexual arousal
Hozzn	حزن	Sadness	Deep utter disabling sadness
Hassad & Al-ayn	العين حسد	Envy and Evil eye	Meaning sight, surveillance, attention, and other related concepts. cast by a malevolent glare, usually given to a person when they are unaware. receiving the evil eye will cause misfortune or injury
Ayeb	عيب	Stigma and shame	A shameful act that brings shame upon the family, ruining the person's social status and "face". A strong cultural expression representing shame. Some Saudi families use "Ayeb" to refer to the person's private parts.
Rejal	لار جولة	Manhood	Masculinity, Strength, not weak, does not cry or complain, respect women, takes care of his family
Ma nekallam annah "anno"	ما نكللم عه	unmentionable	Wilful ignorance, the traditional act of avoidance
Za'alan	زان	angry	Sad- agitated- angry- upset- frustrated- annoyed-unhappy- face frwned

CALD	n/a		Culturally and Linguistically Diverse Community
Rogya Sharia	رقية شرعية	Exorcism	faith healing, Islamic healing that refers to reading verses of the Quran manly and using the “Sunnah” which are the teachings of Prophet Mohammad
Ta’baneen	تعابنين	Unwell	Not normal, sick, ill, mentally ill, lazy, useless and/or tired
sahaba	صحابه	companions	Refers to the companions, friends and family of the Islamic prophet, Muhammad.
Kharaz Azraq	خرز أزرق	Blue Bead	Eye-shaped or round amulet, stone or bead believed to protect against the evil eye. Charm for protection
MashAllah	ما شاء الله	God has willed it OR God’s will	The present perfect of God's will accentuating the essential Islamic doctrine of predestination, use traditionally as a “Charm” to not inflict “evil eye” on someone

Online survey Qualtrics
Mental Health Literacy in the Arabic Speaking Community
June 30th 2019, 8:59 pm MDT
Please contact SGR for a copy



